

3301

CERTIFICATE OF DEATH

03228

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|---|--|---|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Middletown</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Middletown</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Lola</u> Middle <u>E.</u> Last <u>Ahalt</u> | | | | 4. DATE OF DEATH Month <u>3</u> Day <u>28</u> Year <u>1960</u> | | | |
| 5. SEX <u>female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10/19/1874</u> | 9. AGE (In years lost birthday) <u>85</u> yrs. | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Henry Beachley</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Rebecca Rensburg</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | | INFORMANT Address <u>Lloyd Ahalt, Middletown, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> <u>199.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour a. m. <u> </u> p. m. <u> </u> | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>3/19</u> , 19 <u>60</u> to <u>3/28</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3/26</u> , 19 <u>60</u> , and that death occurred at <u>11:20 P. M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Kenneth C. Henson</u> | | | | ADDRESS (Street, city or town, state) <u>Middletown, Md.</u> | | DATE SIGNED <u>3/29/60</u> | |
| PHYSICIAN'S NAME (Type) <u>Dr. Kenneth Henson</u> | | | | <u>Middletown, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> | | 22b. DATE THEREOF <u>3/31/1960</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Middletown, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Company, Middletown, Md.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>APR 1 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hens</u> | |

3261

CERTIFICATE OF DEATH

03229

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | | c. LENGTH OF STAY IN 1b Months | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 419 West South Street | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First SYLVIA Middle IRENE Last ALEXANDER | | | | 4. DATE OF DEATH Month March Day 15 Year 1960 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH December 26, 1881 | |
| 9. AGE (In years last birthday) yrs. 78 | | IF UNDER 1 YEAR Months 78 Days 78 Hours 78 Min. 78 | | IF UNDER 24 HRS. Months 78 Days 78 Hours 78 Min. 78 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work | | | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME Michael Anders | | | | 14. MOTHER'S MAIDEN NAME Mary Catherine Rhoderick | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. 213-24-9580 | | | |
| 17. INFORMANT Mr. Horace M. Alexander-Same as Item #2 | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Arterio-sclerotic heart dis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 18 yrs. (c) 18 yrs. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from May 17, 1953 to 15 March, 1960 that I last saw the deceased alive on 17 Feb 1960 , and that death occurred at 6:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Professional Building DATE SIGNED 3/16/60 ACTUAL SIGNATURE Charles H. Conleym Jr. M.D. Frederick, Maryland PHYSICIAN'S NAME (Type) Charles H. Conleym Jr., M. D. Frederick, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Mar. 18, 1960 | | 22c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery | | 22d. LOCATION (City, town, or county) (State) Woodsboro, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | | | 24a. REC'D BY REGISTRAR MAR 21 '60 | | | |
| 24b. REGISTRAR'S SIGNATURE Arthur L. Kram | | | | | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03230

3298

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|---|------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Emmitsburg</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Emmitsburg</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Saint Mary College</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Car</u> Last <u>Appleton</u> | | 4. DATE OF DEATH Month <u>March</u> Day <u>23</u> Year <u>1960</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8/22/1900</u> |
| 9. AGE (In years last birthday) <u>59</u> yrs. | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Mass.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Unknown</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>EC-12-4460</u> | |
| 17. INFORMANT <u>Mt. St. Mary's records</u> | | Address <u>Emmitsburg, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Alcoholism</u> DUE TO (c) <u> </u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>B.O. Thomas</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>B.O. Thomas</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | <u>March 23, 1960</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>3-26-60</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>St. Anthony Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Emmitsburg, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Creager</u> | | ADDRESS <u>Thurmont, Md.</u> | |
| 24a. REC'D BY REGISTRAR DATE <u>MAR 28 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneal</u> | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68230

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|-----------------------|--|-----------------|--|-------------------|--|------------------|--|------------------|--|-----------------|--|----------------|--|---------------------------------|--|-----------------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY | | COUNTY | | STATE | |
| Mr. J. J. Jones | | 45 | | Male | | White | | 1880 | | Maryland | | Baltimore | | Baltimore | | Maryland | |
| OCCUPATION | | EDUCATION | | MARRIAGE | | RELIGION | | SINGLE | | MARRIED | | DIVORCED | | WIDOWED | | OTHER | |
| Teacher | | High School | | Married | | Roman Catholic | | Single | | Married | | Divorced | | Widowed | | Other | |
| CAUSE OF DEATH | | MANNER OF DEATH | | PERIOD OF ILLNESS | | PREVIOUS ILLNESS | | PREVIOUS SURGERY | | PREVIOUS TRAUMA | | PREVIOUS DRUGS | | PREVIOUS ALCOHOL | | PREVIOUS TOBACCO | |
| Heart Failure | | Natural | | 10 days | | None | | None | | None | | None | | None | | None | |
| SIGNATURE OF EXAMINER | | DATE | | TIME | | PLACE | | CITY | | COUNTY | | STATE | | FEDERAL BUREAU OF INVESTIGATION | | U. S. DEPARTMENT OF JUSTICE | |
| J. J. Jones | | 1920 | | 10:00 AM | | Baltimore | | Baltimore | | Baltimore | | Maryland | | Baltimore | | Washington, D. C. | |

RECEIVED
JAN 10 1920
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

CERTIFICATE OF DEATH

Reg. Dist. No.

3262

03231

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | c. LENGTH OF STAY IN 1b 2 Hours | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First RICHARD Middle PORTER Last BAER | | 4. DATE OF DEATH Month March Day 10 Year 19 60 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH September 9, 1884 |
| 9. AGE (In years and birthday) yrs. 75 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman (Ret) | | 10b. KIND OF BUSINESS OR INDUSTRY Mfg. Co. | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John R. Baer | | 14. MOTHER'S MAIDEN NAME Margaret Schwearing | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 214-10-2149 | |
| 17. INFORMANT Mr. J. Emory Baer, Frederick, Maryland | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Ischemia 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Sclerosis DUE TO (c) Diabetes Mellitus | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pyloric (right) | | INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs 5 years. 5 years | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 3/7 , 19 55 , to 3/10 , 19 60 , that I last saw the deceased alive on 3/10 , 19 60 , and that death occurred at 2:25 A M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE S. R. Schoolman M.D. | | ADDRESS (Street, city or town, state) Professional Building DATE SIGNED 3/11/60 | |
| PHYSICIAN'S NAME (Type) L. R. Schoolman, M.D. | | Frederick, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Mar. 14, 1960 | 22c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery | 22d. LOCATION (City, town, or county) (State) Frederick, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | 24a. REC'D BY REGISTRAR MAR 14 '60 | |
| 24b. REGISTRAR'S SIGNATURE Arthur L. Hume | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1883

CERTIFICATE OF DEATH

3202

1. Name of deceased: _____

2. Age: _____

3. Sex: _____

4. Date of birth: _____

5. Date of death: _____

6. Place of death: _____

7. Cause of death: _____

8. Signature of physician: _____

9. Signature of registrar: _____

10. Date of registration: _____

CERTIFICATE OF DEATH

Reg. Dist. No.

03232

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural-R.D.#4 | | c. LENGTH OF STAY IN 1b 3 Years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Teen Barnes Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First MARSHALL Middle COLUMBUS Last BAKER | | 4. DATE OF DEATH Month March Day 14 Year 19 60 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH October 12, 1906 |
| 9. AGE (In years last birthday) yrs. 53 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail Bread Route | | 10b. KIND OF BUSINESS OR INDUSTRY Salesman | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Charles W. Baker | | 14. MOTHER'S MAIDEN NAME Mollie Umberger | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 220-18-1733 | |
| 17. INFORMANT Address Mrs. Virginia I. Baker-Same as item #2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Carcinoma of rectum DUE TO (c) 1 yr. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 8:15 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Melvin E. Lea | | ADDRESS (Street, city or town, state) Frederick Medical Center DATE SIGNED 3/17/60 | |
| PHYSICIAN'S NAME (Type) Melvin E. Lea., M.D. | | Frederick, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Mar. 18, 1960 | 22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | 22d. LOCATION (City, town, or county) (State) Frederick, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | 24a. REC'D BY REGISTRAR DATE MAR 21 '60 | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

3303 - CERTIFICATE OF DEATH

11-1-11

11-1-11

11-1-11

11-1-11

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11-1-11

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3263

CERTIFICATE OF DEATH

Reg. Dist. No.

03233

| | | | |
|---|-------------------------------|--|--------------------------------|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 35 Brunswick | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Three Pines Nursing Home | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Charles F Barnard | | 4. DATE OF DEATH 3 Month 3 Day 1960 Year | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH ? 1871 |
| 9. AGE (In years last birthday) 89 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY - | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Spanish American | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | |
| 17. INFORMANT Mrs. Lawrence Himes, Knoxville, Maryland | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Cardiovascular Disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (b) DUE TO (c) (c) | | INTERVAL BETWEEN ONSET AND DEATH 5 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 3-1 , 19 60 , to 3-1 , 19 60 , that I last saw the deceased alive on 3-1 , 19 60 , and that death occurred at 6:15 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE U. G. Bourne Jr M.D. Frederick PHYSICIAN'S NAME (Type) U. G. Bourne Jr | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3-7-1960 | |
| 22c. NAME OF CEMETERY OR CREMATORY Brothern | | 22d. LOCATION (City, town, or county) (State) Brownsville, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE G. W. Lutz ADDRESS Brunswick, Maryland | | 24a. REC'D BY REGISTRAR DATE MAR 14 '60 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Himes | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | |
|--|--|---|---|---|--|--|--|--|--|---|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND | | | | | | | | | | | | | | |
| 3264 CERTIFICATE OF DEATH 03234 | | | | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY FREDERICK b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK CITY d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK CITY HOSPITAL | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ADAMSTOWN, MARYLAND d. STREET ADDRESS BOX 34 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last GORDON DeWITT BEAM | | | | | 4. DATE OF DEATH Month Day Year March 25 19 60 | | | | | | | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH July 24, 1886 | | 9. AGE (In years less birthday) yrs. 73 | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Dairy Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Dairy | | 11. BIRTHPLACE (State or foreign country) North Carolina | | | 12. CITIZEN OF WHAT COUNTRY? U.S/A | | | | | | | |
| 13. FATHER'S NAME EDWARD BEAM | | | | | 14. MOTHER'S MAIDEN NAME MARY KATE BENNETT | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI | | | | | 16. SOCIAL SECURITY NO. 577-18-5431 | | | | | 17. INFORMANT Address Mrs. Eunice Beam Adamstown, Maryland | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sub-arachnoid hemorrhage 330X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus, mild, Pulmonary Emphysema | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 17 days | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from March 4, 1960 , to March 25, 1960 , that (I) (we) last saw the deceased alive on March 24, 1960 , and that death occurred at 3:58 AM , from the causes and on the date stated above. | | | | | | | | | | 22b. DATE SIGNED 3-25-60 | | | | |
| 22a. SIGNATURE Robert S. Turner, Jr. M.D. 22c. PHYSICIAN'S NAME (Type) ROBERT S. TURNER, JR. | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 7 E. CHURCH ST. FREDERICK, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE THEREOF 3-29-60 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cem. | | | 23d. LOCATION (City, town, or county) Arlington, Virginia (State) | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland | | | | | 25a. REC'D BY REGISTRAR DATE MAR 30 '60 | | | 25b. REGISTRAR'S SIGNATURE Arthur S. Knaus | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3265

CERTIFICATE OF DEATH

Reg. Dist. No.

03235

| | | | |
|--|-------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural, Mt. Pleasant</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>EDWARD</u> Last <u>BEARD</u> | | 4. DATE OF DEATH Month <u>March</u> Day <u>11</u> Year <u>1960</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 26 1898</u> |
| 9. AGE (In years last birthday) <u>81</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John D. Beard</u> | | 14. MOTHER'S MAIDEN NAME <u>Barbara Ellen Burrier</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>42-38-8607</u> | |
| 17. INFORMANT <u>Mrs. Mary E. Beard, Frederick Rl, Md.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma prostate</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastases to pelvis, spine, lungs</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Aug</u> , 1959, to <u>March 11</u> , 1960, that I lost sows the deceased olive on <u>10 March</u> , 1960, and that death occurred at <u>8:20 A.M.</u> from the causes and on the date stated above. | | | |
| ADDRESS (Street, city or town, state) <u>Walkersville, Md.</u> | | DATE SIGNED <u>12 March 60</u> | |
| ACTUAL SIGNATURE <u>James E. Stoner, Jr.</u> | | M.D. | |
| PHYSICIAN'S NAME (Type) <u>JAMES E. STONER, JR.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>3/10/60</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Chapel Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Mt. Libertytown, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>G.C. Barton</u> | | ADDRESS <u>Walkersville Md</u> | |
| 24a. REC'D BY REGISTRAR DATE <u>MAR 16 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u> | |

09335

CERTIFICATE OF DEATH

3861

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

Page Two of Two

| | | | |
|---|--|----------------------------|--|
| PLACE OF DEATH | | MAY 1961 | |
| 1. CITY OR TOWN IN WHICH DEATH OCCURRED | | 2. COUNTY | |
| 3. STATE | | 4. ZIP CODE | |
| 5. DEATH CERTIFICATE NO. | | 6. DEATH CERTIFICATE NO. | |
| 7. DEATH CERTIFICATE NO. | | 8. DEATH CERTIFICATE NO. | |
| 9. DEATH CERTIFICATE NO. | | 10. DEATH CERTIFICATE NO. | |
| 11. DEATH CERTIFICATE NO. | | 12. DEATH CERTIFICATE NO. | |
| 13. DEATH CERTIFICATE NO. | | 14. DEATH CERTIFICATE NO. | |
| 15. DEATH CERTIFICATE NO. | | 16. DEATH CERTIFICATE NO. | |
| 17. DEATH CERTIFICATE NO. | | 18. DEATH CERTIFICATE NO. | |
| 19. DEATH CERTIFICATE NO. | | 20. DEATH CERTIFICATE NO. | |
| 21. DEATH CERTIFICATE NO. | | 22. DEATH CERTIFICATE NO. | |
| 23. DEATH CERTIFICATE NO. | | 24. DEATH CERTIFICATE NO. | |
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| 97. DEATH CERTIFICATE NO. | | 98. DEATH CERTIFICATE NO. | |
| 99. DEATH CERTIFICATE NO. | | 100. DEATH CERTIFICATE NO. | |

1. The undersigned hereby certifies that the foregoing is a true and correct copy of the original death certificate as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day of the month of May, 1961, at the City of Baltimore, Maryland.

2. The undersigned hereby certifies that the foregoing is a true and correct copy of the original death certificate as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day of the month of May, 1961, at the City of Baltimore, Maryland.

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10. The undersigned hereby certifies that the foregoing is a true and correct copy of the original death certificate as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day of the month of May, 1961, at the City of Baltimore, Maryland.

3266 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 CERTIFICATE OF DEATH

Reg. Dist. No.

03236

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | c. LENGTH OF STAY IN 1b Lifetime | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 345 East Patrick Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Effie Middle May Last Bell | | 4. DATE OF DEATH Month March Day 8 Year 1960 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 15, 1880 |
| 9. AGE (In years last birthday) 79 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | 11. IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY None | 11. BIRTHPLACE (State or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME William T. Umberger | |
| 14. MOTHER'S MAIDEN NAME Margaret Webb | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | |
| 16. SOCIAL SECURITY NO. 212-24-6979 | | 17. INFORMANT Address Mrs. Martha B. Mock 345 East Patrick Street. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yr. 10 Years | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 3-8 , 19 60 , to 3-8 , 19 60 , that I last saw the deceased alive on 3-10 , 19 60 , and that death occurred at 9:00 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Robert S. Turner, Jr. M.D. _____ PHYSICIAN'S NAME (Type) Dr. Robert S. Turner, Jr. M.D. 7 East Church Street Frederick, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 3-11-1960 | 22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | 22d. LOCATION (City, town, or county) (State) Frederick, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert S. Turner, Jr. ADDRESS Frederick, Maryland | | 24a. REC'D BY REGISTRAR MAR 11 1960 DATE | 24b. REGISTRAR'S SIGNATURE Robert S. Turner |

02338

CERTIFICATE OF DEATH

3586

WEST VIRGINIA DEPARTMENT OF HEALTH
HARRISBURG, WEST VIRGINIA

DATE OF DEATH: _____

TIME OF DEATH: _____

PLACE OF DEATH: _____

AGE: _____

SEX: _____

RACE: _____

EDUCATION: _____

OCCUPATION: _____

CAUSE OF DEATH: _____

IMMEDIATE CAUSE: _____

UNDERLYING CAUSE: _____

PREVIOUS ILLNESS: _____

PREVIOUS SURGERY: _____

PREVIOUS TRAUMA: _____

PREVIOUS DRUGS: _____

PREVIOUS ALCOHOL: _____

PREVIOUS TOBACCO: _____

PREVIOUS OTHER: _____

SIGNATURE OF PHYSICIAN: _____

SIGNATURE OF CORONER: _____

SIGNATURE OF WITNESS: _____

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO REMAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND | | | | | | | | | | | |
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| 3267 Item 14 Film 258 3-10-60 et | | | | | | | | | | | |
| 03237 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Frederick | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY Frederick Mont. | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fred. Rural -- Germantown | | 15X-2 | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital | | d. STREET ADDRESS Montgomery County | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last VELMA LARUE BELL | | 4. DATE OF DEATH Month Day Year MARCH 1 1960 | | | | | | | | | |
| 5. SEX F | | 6. COLOR OR RACE C | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Jan. 19-60 | | 9. AGE (In years last birthday) 1 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. 1 14 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ***** | | 10b. KIND OF BUSINESS OR INDUSTRY ***** | | 11. BIRTHPLACE (State or foreign country) Frederick, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 13. FATHER'S NAME Herman Carter | | 14. MOTHER'S MAIDEN NAME Margaret Gray (Married Name Bell) | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. ***** | | 17. INFORMANT Hospital Records | | Address | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 571.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Gastro-enteritis - non-specific | | INTERVAL BETWEEN ONSET AND DEATH 2 weeks | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 2/14 19 60 to 3/1 19 60 , that (I) (we) last saw the deceased alive on 3/1 19 60 , and that death occurred at 11:25 AM, from the causes and on the date stated above. | | 22a. SIGNATURE James B. Thomas | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | | | | | |
| 22c. PHYSICIAN'S NAME (Type) James B. Thomas | | 22d. ADDRESS Professional Building - Fred. Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF March 2-60 | | 23c. NAME OF CEMETERY OR CREMATORY Long Hill | | 23d. LOCATION (City, town, or county) (State) Hystown Maryland | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE C.E. Hicks 111 | | ADDRESS Frederick, Maryland | | 25a. REC'D BY REGISTRAR DATE MAR 7 '60 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | | | |

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STATE OF NEW YORK

1938

IN SENATE

January 11, 1938

REPORT

OF THE

COMMISSIONER

OF THE

DEPARTMENT OF

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03238

| | | | |
|---|---------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <i>Frederick</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Cornwall</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Keymar</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Memorial Hosp.</i> | | d. STREET ADDRESS <i>06X-2</i> | |
| 3. NAME OF DECEASED (Type or print) <i>First Middle Last</i> <i>Miss Lula VIOLA Birely</i> | | 4. DATE OF DEATH <i>March 7 1960</i> | |
| 5. SEX <i>F</i> | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Nov. 28, 1878</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House work</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Oliver David Birely</i> | | 14. MOTHER'S MAIDEN NAME <i>Mary Ellen Angell</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> | | 16. SOCIAL SECURITY NO. <i>219-20-0308A</i> | |
| 17. INFORMANT <i>Mr Lewis S. Birely, Jackson, Mich.</i> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X Cerebral Haemorrhage</i> DUE TO (b) <i>Hypertension</i> DUE TO (c) <i>Arteriosclerosis</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Obesity</i> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>March 4 1960</i> to <i>March 7 1960</i> that (I) (we) last saw the deceased alive on <i>March 7 1960</i> , and that death occurred at <i>12:30</i> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>A. A. Pearre</i> | | 22b. DATE SIGNED <i>3/7/60</i> | |
| 22c. PHYSICIAN'S NAME (Type) <i>A. A. PEARRE</i> | | 22d. ADDRESS <i>4 E. Church St. Frederick, Md.</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE THEREOF <i>Mar. 10, 1960</i> | |
| 23c. NAME OF CEMETERY OR CREMATORY <i>W. Ladysburg</i> | | 23d. LOCATION (City, town, or county) (State) <i>Md.</i> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <i>G. C. Barton</i> | | 25a. REC'D BY REGISTRAR <i>Walker, Md.</i> | |
| 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i> | | DATE <i>MAR 10 '60</i> | |

03314

WATKINS AND COMPANY, NEW YORK

CERTIFICATE OF DEATH

3503

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11/11/11

WATKINS AND COMPANY

NEW YORK

11/11/11

3303

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE PENNA b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Ijamsville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ST. DAVIDS 75X-3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Riggs Hospital | | d. STREET ADDRESS 601 GLENMARY LANE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Edith First L Middle Bonyun Last | | 4. DATE OF DEATH March 3 Day Year 1960 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec 7 1881 |
| 9. AGE (In years last birthday) 78 | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE | 11. BIRTHPLACE (State or foreign country) PA |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A | | 13. FATHER'S NAME STEPHEN DOUGLASS LIPPINCOTT | |
| 14. MOTHER'S MAIDEN NAME HARRIET ORVILLE MYERS | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. L | | 17. INFORMANT RIGGS HOSPITAL Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) cerebral Arteriosclerosis | | | INTERVAL BETWEEN ONSET AND DEATH 20 yrs |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from March 17, 1954, to March 3, 1960, that I last saw the deceased alive on March 3, 1960, and that death occurred at 11.00M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Joseph Lerner M.D. | | DATE SIGNED March 3 '60 | |
| PHYSICIAN'S NAME (Type) Joseph Lerner M.D. | | Ijamsville Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION | 22b. DATE THEREOF MAR 4-60 | 22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CREM | 22d. LOCATION (City, town, or county) (State) WASHINGTON D.C. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Lucian K. Falcone | | ADDRESS New Market Md | 24a. REC'D BY REGISTRAR DATE MAR 8 '60 |
| | | 24b. REGISTRAR'S SIGNATURE Arthur S. Frank | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1004 *Wang et al.*

CERTIFICATE OF DEATH

Reg. Dist. No.

03240

3269

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|---|------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | c. LENGTH OF STAY IN 1b Since 3-23-60 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First BERTHA Middle LOUISE Last BOWLUS | | 4. DATE OF DEATH Month March Day 30 Year 1960 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7 June 1871 |
| 9. AGE (In years last birthday) yrs. 88 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | |
| 11. BIRTHPLACE (State or foreign country) Fairplay, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Joseph M. Rowland | | 14. MOTHER'S MAIDEN NAME Ann Elizabeth Emmert | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Rev. John S. Bowlus (Same as item #2) | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH minutes 4 years | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 3/23 , 19 60 to 3/29 , 19 60 , that I last saw the deceased alive on 3/29 , 19 60 , and that death occurred at 7:15 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9 E. Church St. DATE SIGNED 30 March 1960 | | | |
| ACTUAL SIGNATURE Richard C. Reynolds, M.D. | | DATE SIGNED 30 March 1960 | |
| PHYSICIAN'S NAME (Type) Richard C. Reynolds, M. D. | | Frederick, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 4-2-60 | 22c. NAME OF CEMETERY OR CREMATORY Pleasant View Cemetery | 22d. LOCATION (City, town, or county) (State) Near Burkittsville, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | 24a. REC'D BY REGISTRAR DATE APR 1 1960 | |
| | | 24b. REGISTRAR'S SIGNATURE Charles S. Threlk | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
OFFICE OF THE COMMISSIONER OF HEALTH

ALBANY, N. Y., JANUARY 1, 1900.

SIR:

I have the honor to acknowledge the receipt of your letter of the 28th inst.

in relation to the matter of the death of the late

JOHN J. HENRY, deceased, and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,
Yours very truly,
J. J. HENRY

Commissioner of Health

Enclosed for you are two copies of the report of the

coroner's jury in the case of the late JOHN J. HENRY, deceased.

I am, Sir, very respectfully,
Yours very truly,
J. J. HENRY

Commissioner of Health

Very truly,
J. J. HENRY

Commissioner of Health

Very truly,
J. J. HENRY

Commissioner of Health

Very truly,
J. J. HENRY

Commissioner of Health

Very truly,
J. J. HENRY

3304

CERTIFICATE OF DEATH

03241

Reg. Dist. No.

| | | | | | | | |
|--|--|---|---|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Middletown | | | c. LENGTH OF STAY IN 1b 4 weeks | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Middletown | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS 1 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Mary E. H. Middle Bowlus Last | | | | 4. DATE OF DEATH Month 2 Day 28 Year 19 60 | | | |
| 5. SEX female | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 2/28/1876 | |
| 9. AGE (In years last birthday) 84 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY own home | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. | |
| 13. FATHER'S NAME Lawson Haupt | | | | 14. MOTHER'S MAIDEN NAME Mary Dutrow | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. none | | INFORMANT Address J. Grayson Bowlus, Middletown, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) Adv. Cerebro Sclerosis DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Aug , 19 59 to Mar 28 19 60 , that I last saw the deceased alive on Mar 27 19 60 , and that death occurred at 12:30 P. M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE J. Elmer Harp M.D. | | | | ADDRESS (Street, city or town, state) DATE SIGNED Middletown 3-29-60 | | | |
| PHYSICIAN'S NAME (Type) Dr. J. Elmer Harp | | | | Middletown, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 22b. DATE THEREOF 3/30/1960 | | 22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery | | 22d. LOCATION (City, town, or county) (State) Middletown, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, | | | | ADDRESS Middletown, Md. | | 24a. RECEIVED BY REGISTRAR MAR 31 60 DATE | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur L. Evans | | | |

MEDICAL CERTIFICATION

pp

11360

3304 CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

[Faint, mostly illegible text on a form with horizontal lines. The text appears to be a record of a death, possibly from the early 20th century. Some legible fragments include:]

[Faint text at the top right, possibly a date:] JAN 1904

[Faint text in the middle:] DECEASED

[Faint text at the bottom:] BUREAU OF VITAL RECORDS



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3305

CERTIFICATE OF DEATH

Reg. Dist. No.

03242

| | | | | | | | |
|---|-------------------------------|---|------------------------------------|--|---|---|--|
| 1. PLACE OF DEATH o. COUNTY <i>Frederick</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>Frederick</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick R#7</i> | | c. LENGTH OF STAY IN 1b <i>191 days</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X new Windsor</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick County Chronic Hospital</i> | | | | d. STREET ADDRESS <i>1</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <i>Flora</i> Middle <i>Browning</i> Last <i>Browning</i> | | | | 4. DATE OF DEATH Month <i>3</i> Day <i>29</i> Year <i>1960</i> | | | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>W.</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>6/12/82</i> | | 9. AGE (In years lost birthday) yrs. <i>77</i> | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i> | | 11. BIRTHPLACE (State or foreign country) <i>Luray, Va.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>William Hart</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Anna Lee Braden</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>None</i> | | 17. INFORMANT <i>Ruth Crawford Rn. Frederick County Chronic Hosp.</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma Colon</i> <i>153.8</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>15 mos.</i> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>Jan</i> , 19 <i>59</i> , to <i>Mar 29</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>3/29</i> , 19 <i>60</i> , and that death occurred at <i>12:00 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>7 N. Market St.</i> DATE SIGNED <i>31 March 1960</i> | | | | | | | |
| ACTUAL SIGNATURE <i>H. F. Kline</i> M.D. | | | | PHYSICIAN'S NAME (Type) <i>H. F. Kline, M. D.</i> Frederick, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>Apr. 4, 1960</i> | | 22c. NAME OF CEMETERY OR CREMATORY <i>Mount Olivet Cemetery</i> | | 22d. LOCATION (City, town, or county) (State) <i>Frederick, Maryland</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>M. R. Etchison & Son, Frederick, Maryland</i> | | | | 24a. REC'D BY REGISTRAR DATE <i>APR 5 '60</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3270

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | | |
|--|----------------------------------|---|---|--|---|---|--|--|
| 1. PLACE OF DEATH o. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | c. LENGTH OF STAY IN 1b Days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 325 Reedwood Avenue | | | | d. STREET ADDRESS 15 East Fifth Street | | | | |
| 3. NAME OF DECEASED (Type or print) First JOHN Middle WILLIAM Last BRUCHEY, SR. | | | | 4. DATE OF DEATH Month March Day 12 Year 1960 | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH February 8, 1898 | 9. AGE (In years less birthday) yrs. 62 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brushmaker | | 10b. KIND OF BUSINESS OR INDUSTRY Brush Co. | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Charles W. Bruchey | | | | 14. MOTHER'S MAIDEN NAME Fannie Ainsworth | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 214-10-2640 | | INFORMANT Mrs. Helen M. Fox, Frederick, Maryland | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arterio-sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Thrombosis | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 months 5 years | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from Jan. 2 , 19 48 to March 12 , 19 60 that I last saw the deceased alive on March 10 , 19 60 , and that death occurred at 11:30A , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Professional Building DATE SIGNED 3/15/60 | | | | | | | | |
| ACTUAL SIGNATURE B. O. Thomas Jr | | M.D. Frederick, Maryland | | | | | | |
| PHYSICIAN'S NAME (Type) B. O. Thomas, Jr., M.D. | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Mar. 16, 1960 | | 22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | | 22d. LOCATION (City, town, or county) (State) Frederick, Maryland | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | | | 24a. REC'D BY REGISTRAR DATE MAR 18 '60 | | 24b. REGISTRAR'S SIGNATURE Orlino L. Thomas | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

1954

CERTIFICATE OF DEATH

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3306

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03244

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont rural | | c. LENGTH OF STAY IN lb 60 yrs. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) First Ernest Middle Harvey Last Carbaugh | | 4. DATE OF DEATH Month March Day 25 Year 1960 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 9-30-1897 |
| 9. AGE (In years last birthday) 62 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Orchard | 11. BIRTHPLACE (State or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Emanuel Carbaugh | |
| 14. MOTHER'S MAIDEN NAME Mary Ellen Connor | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I | |
| 16. SOCIAL SECURITY NO. 231-01-9322 | | 17. INFORMANT Mrs. Wm. I. Sweeney Address Thurmont, Md. RD | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Exposure (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH minutes minutes | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE B.O. Thomas | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) B.O. Thomas | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3-27-60 | |
| 22c. NAME OF CEMETERY OR CREMATORY Lewistown Cemetery | | 22d. LOCATION (City, town, or county) (State) Lewistown, Md. Fred. Co. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager | | ADDRESS Thurmont, Md. | |
| 24a. REC'D BY REGISTRAR MAR 28 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus | |

DATE SIGNED

Mch. 25. 1960

RECEIVED
JAN 10 1960
STATE DEPT. OF HEALTH
DIVISION OF VITAL RECORDS
1000 PENNSYLVANIA AVE., N.W.
WASHINGTON, D.C. 20540

2301

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Fredrick

Maryland

Fredrick

Harmon, Samuel

60 yrs.

Harmon, Samuel

MD 1

Robert

Harvey

Carroll

Harmon

60

Male

White

6-2-1900

1860

Harmon

Operator

Maryland

U.S.A.

Samuel Harmon

Harmon, Samuel

201-01-1222

Harmon, Samuel

Harmon, Samuel

B. C. Thomas

2-27-60

Lewisburg Company

Lewisburg, Md.

Co.

Feb. 25, 1960

3271 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03245

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | c. LENGTH OF STAY IN 1b 10 years | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital | | d. STREET ADDRESS 508 Elm Street | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) Richard Clare Cox | | 4. DATE OF DEATH Month March Day 12 Year 19 60 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 12, 1890 |
| 9. AGE (In years last birthday) 69 yrs. | | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanical Design Engineer | | 10b. KIND OF BUSINESS OR INDUSTRY Mattoon, Illinois | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Franklin Cox | | 14. MOTHER'S MAIDEN NAME Jenny Hughie | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 097-14-2715 | 17. INFORMANT Address Mrs. Martha Cox (Wife) 508 Elm Street |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebella Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertensive Heart disease (c) 2 yrs + DUE TO cause lost. | | | INTERVAL BETWEEN ONSET AND DEATH 2 hours |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE B O Thomas | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Dr. B. O. Thomas, Sr. | | M.D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3-15-60 | 22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery |
| 22d. LOCATION (City, town, or county) Frederick, Maryland | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert E. Darby Jr. | | ADDRESS Frederick, Maryland | |
| 24a. REC'D BY REGISTRAR MAR 16 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3307

CERTIFICATE OF DEATH

03140

Reg. Dist. No.

| | | | |
|---|--------------------|--|----------------------------|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Victor Cullen State Hospital | | d. STREET ADDRESS 900 Cathedral St. | |
| 3. NAME OF DECEASED (Type or print) Thompson | | 4. DATE OF DEATH 3 17 19 60 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 6-27-1905 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME George Darling | | 14. MOTHER'S MAIDEN NAME Linda Highner | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 220-01-9561 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis - 002 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 4 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis - 420 | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 4/9 19 59, to 3/17 19 60, that I last saw the deceased alive on 3/17 19 60, and that death occurred at 1:15 PM, from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) DATE SIGNED | |
| ACTUAL SIGNATURE T. F. [Signature] | | M.D. | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Transf. | | 22b. DATE THEREOF 3/18/60 | |
| 22c. NAME OF CEMETERY OR CREMATORY Board of Anatomy, U. of Md. | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Cragg - Thompson | | 24a. REC'D BY REGISTRAR DATE MAR 21 '60 | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur L. Hines | |

CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| NAME OF DECEASED [Faint text, possibly "John Doe"] | | SEX [Faint text, possibly "Male"] | | AGE [Faint text, possibly "45"] | | DATE OF BIRTH [Faint text, possibly "10-15-1880"] | |
| PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."] | | OCCUPATION [Faint text, possibly "Teacher"] | | CAUSE OF DEATH [Faint text, possibly "Heart Disease"] | | MANNER OF DEATH [Faint text, possibly "Natural"] | |
| DATE OF DEATH [Faint text, possibly "10-20-1920"] | | TIME OF DEATH [Faint text, possibly "10:00 AM"] | | PLACE OF DEATH [Faint text, possibly "Home"] | | SIGNATURE OF PHYSICIAN [Faint signature] | |
| SIGNATURE OF REGISTRAR [Faint signature] | | SIGNATURE OF WITNESS [Faint signature] | | SIGNATURE OF DECEASED [Faint signature] | | SIGNATURE OF NEAREST RELATIVE [Faint signature] | |
| COUNTY [Faint text, possibly "Baltimore"] | | CITY [Faint text, possibly "Baltimore"] | | STATE [Faint text, possibly "Maryland"] | | ZIP CODE [Faint text, possibly "21201"] | |

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy of the same is to be sent to the local health officer of the city or county in which the death occurred.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03246

3272

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH o. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | c. LENGTH OF STAY IN TB 2 days | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital | | d. STREET ADDRESS 1 | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Wilbur Middle Franklin Last Davis | | 4. DATE OF DEATH Month March Day 1 , Year 1960 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 24, 1906 |
| 9. AGE (In years last birthday) 54 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator | 10b. KIND OF BUSINESS OR INDUSTRY Moore Bus. Forma | 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME McClellan Davis | | 14. MOTHER'S MAIDEN NAME Sarah Yingling | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. 217-05-7302 | 17. INFORMANT Mrs. Geneva Davis Address Thurmont, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBAR PNEUMONIA 490x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PROGRESSIVE MUSCULAR ATROPHY | | | INTERVAL BETWEEN ONSET AND DEATH 6 days |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) (County) (State) | | 21. I certify that I attended the deceased from 3/27 , 19 60 , to 3/1 , 19 60 , that I last saw the deceased alive on 3/29 , 19 60 , and that death occurred at 4:00 A.M. from the causes and on the date stated above. | |
| ACTUAL SIGNATURE Richard C. Reynolds M.D. | | ADDRESS (Street, city or town, state) DATE SIGNED | |
| PHYSICIAN'S NAME (Type) Richard C. Reynolds | | 9 E. Church St. Frederick, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 3-4-60 | 22c. NAME OF CEMETERY OR CREMATORY Graceham Cemetery | 22d. LOCATION (City, town, or county) (State) Graceham Fred. Co. Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager | | ADDRESS Thurmont, Md. | 24a. REC'D BY REGISTRAR DATE MAR 3 '60 |
| | | 24b. REGISTRAR'S SIGNATURE Arthur S. Travis | |

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Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban permits. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3273

CERTIFICATE OF DEATH

Reg. Dist. No.

03247

| | | | |
|---|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | c. LENGTH OF STAY IN 1b Life | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 129 West Third Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Charlotte Trammell DeLashmutt | | 4. DATE OF DEATH March 2, 19 60 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 30, 1889 |
| 9. AGE (In years lost birthday) 70 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired School Teacher | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Edward T. H. DeLashmutt | | 14. MOTHER'S MAIDEN NAME Emma Alvida Thomas | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 219-36-4174 | |
| 17. INFORMANT Miss Alvida DeLashmutt (Sister) | | Address 129 W. 3rd St. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pneumonia 492x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Hemorrhage INTERVAL BETWEEN ONSET AND DEATH 3 days | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Mar 1, 1960 to Mar 1, 1960 that I last saw the deceased alive on Mar 1, 1960 , and that death occurred at 6 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE H. F. Kline | | DATE SIGNED 7-11-7-Marcher St Frederick Md Mar 60 | |
| PHYSICIAN'S NAME (Type) Dr. H. F. Kline M.D. | | 7 North Market Street Frederick, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3-1-1960 | |
| 22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | | 22d. LOCATION (City, town, or county) (State) Frederick, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert E. Dwyer | | 24a. REC'D BY REGISTRAR Arthur S. Kline | |
| ADDRESS Frederick, Maryland | | DATE MAR 4 '60 | |

02873

CERTIFICATE OF DEATH

1973

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

Form with multiple lines for text entry, including fields for name, date, and location. The text is faint and mostly illegible.



3308

CERTIFICATE OF DEATH

Reg. Dist. No.

03248

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Warren | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Middletown | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Front Royal 83X-3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Valley View Nursing Home | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) ORPHA SUSAN DOMAN | | 4. DATE OF DEATH Month March Day 23 Year 19 60 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH October 6, 1874 |
| 9. AGE (In years last birthday) 85 yrs. | | 10. IF UNDER 1 YEAR Months 2 Days 4 Hours 0 Min. | 11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY own home | |
| 11. BIRTHPLACE (State or foreign country) West Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Morgan McQuain | | 14. MOTHER'S MAIDEN NAME Julia Etta McQuain | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT Mrs W.R. Falkenstein, Myersville, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Generalized Arterio Sclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) 2 yrs DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Feb 19, 1960 to Mar 23, 1960 , that I last saw the deceased alive on Mar 23, 1960 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Middletown DATE SIGNED 3-2-5-60 | | | |
| ACTUAL SIGNATURE J. Elmer Harp M.D. | | PHYSICIAN'S NAME (Type) J. Elmer Harp Middletown, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Mar. 27, 1960 | 22c. NAME OF CEMETERY OR CREMATORY Asbury M. E. | 22d. LOCATION (City, town, or county) (State) Rock Oak, Hardy Co., W. Va. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Paul F. Bittle ADDRESS Myersville, Md. | | 24a. REC'D BY REGISTRAR DATE MAR 28 '60 | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus |

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Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

03348

03309

CENTRAL BANK OF DENMARK

MARY AND STATE OF DENMARK

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03249

3309

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

| | | | | | | | |
|---|----------------------------------|---|--|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT AIRY R 2</u> | | c. LENGTH OF STAY IN 1b <u>YEARS</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XMT AIRY R 2</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>NEAR UNIONVILLE</u> | | | | d. STREET ADDRESS <u>NEAR UNIONVILLE</u> | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>RICHARD MARLIN ECKER</u> | | | | 4. DATE OF DEATH Month <u>MARCH</u> Day <u>5</u> Year <u>1960</u> | | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH <u>AUG 12 - 1909</u> | | 9. AGE (In years last birthday) <u>50</u> yrs. | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTING AND CARPENTERING</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | | | 13. FATHER'S NAME <u>UNKNOWN</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>LENA ECKER</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u> <u>NO</u> | | | |
| 16. SOCIAL SECURITY NO. <u>215-30-3025</u> | | | | 17. INFORMANT <u>CHAS J ECKER MT AIRY R 2 MD.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> DUE TO <u> </u> cause lost. (c) <u> </u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u> </u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | | 20f. (City or town) (County) (State) <u> </u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>B O THOMAS</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>B O THOMAS</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | DATE SIGNED <u>MAR. 5 - 1960</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>3/8/60</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>LINGANORE CEM.</u> | | 22d. LOCATION (City, town, or county) (State) <u>UNIONVILLE, MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Ed Hatcher</u> | | | | ADDRESS <u>LIBERTYTOWN MD</u> | | 24a. REC'D BY REGISTRAR <u> </u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u> | | | | DATE <u>MAR 9 '60</u> | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

3385

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

63810

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, place of death, and cause of death. Includes checkboxes for various conditions and a section for the medical examiner's signature and seal.

NAME: _____
AGE: _____ SEX: _____ RACE: _____
DATE OF DEATH: _____ PLACE OF DEATH: _____
CAUSE OF DEATH: _____
MANNER OF DEATH: _____
MEDICAL EXAMINER'S SIGNATURE: _____
SEAL: _____

Vertical text on the right margin, likely a filing or tracking number, partially obscured by a large black mark.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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3274

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03250

| | | | |
|---|------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Loudoun | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick Mem. Hosp. | | c. LENGTH OF STAY IN lb 2 Weeks | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Mem. Hospital | | d. STREET ADDRESS Rural- Lovettsville | |
| 3. NAME OF DECEASED (Type or print) First Orra Middle LOUISE Last Fawley | | 4. DATE OF DEATH Month March Day 14 Year 1960 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIAGE <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED | 8. DATE OF BIRTH February 23, 1873 |
| 9. AGE (In years last birthday) 87 yrs. | | 10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | |
| 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT George Fawley, Lovettsville, Virginia | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis with infarction of the brain, 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, generalized, severe DUE TO (c) 10 yrs + | | INTERVAL BETWEEN ONSET AND DEATH 2 wks. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 2/28 19 60 , to 3/14 19 60 , that (I) (we) last saw the deceased alive on 3/14 19 60 , and that death occurred at 4 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Henry V. Chase | | 22b. DATE SIGNED 3/14/60 | |
| 22c. PHYSICIAN'S NAME (Type) Henry V. Chase | | 22d. ADDRESS 4 E. Church St Frederick Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 3-16-60 | |
| 23c. NAME OF CEMETERY OR CREMATORY Union Cemetery | | 23d. LOCATION (City, town, or county) (State) Lovettsville, Virginia | |
| 24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | 25a. REC'D BY REGISTRAR DATE MAR 18 '60 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Krump | | | |

03830

CERTIFICATE OF DEATH

3274



Decedent's Name: [Illegible] Sex: [Illegible] Age: [Illegible]

Place of Birth: [Illegible] Date of Birth: [Illegible]

Place of Death: [Illegible]

Date of Death: [Illegible]

Signature of Physician: [Illegible]

[Illegible signature]

[Illegible signature]

[Illegible signature]

[Illegible signature]

[Illegible signature]

[Illegible signature]

[Illegible signature]

[Illegible signature]

[Illegible signature]

Witness: [Illegible]

Witness: [Illegible]

Witness: [Illegible]

Witness: [Illegible]

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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3275

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03251

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | c. LENGTH OF STAY IN 1b Since 3-18-60 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Yvonne Middle M.C. Last Ferrell | | 4. DATE OF DEATH Month March Day 22 Year 1960 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6 June 1883 |
| 9. AGE (In years last birthday) 76 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | 11. IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME James C. Ferrell | | 14. MOTHER'S MAIDEN NAME Laura Delauter | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Miss Ethel Ferrell (Same as item #2) | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) Arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH 5 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Thrombosis | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from March 18, 1960 to March 22, 1960 , that (I) (we) last saw the deceased alive on March 22, 1960 , and that death occurred at 7:30 p.m., from the causes and on the date stated above. | | | |
| 22a. SIGNATURE A. A. Pearre | | 22b. DATE SIGNED 3/22/60 | |
| 22c. PHYSICIAN'S NAME (Type) A. A. Pearre, M. D. | | 22d. ADDRESS Frederick Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 3-26-60 | |
| 23c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery | | 23d. LOCATION (City, town, or county) (State) Jefferson, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | 25a. REC'D BY REGISTRAR DATE MAR 24 '60 | |
| 25b. REGISTRAR'S SIGNATURE William S. Hand | | | |

03521

CONFIDENTIAL

382



be retained by the hospital or attending physician. GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03252

CERTIFICATE OF DEATH

Reg. Dist. No.

3295

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick | | | | c. LENGTH OF STAY IN 1b Life | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 23 West "B" | | | | e. STREET ADDRESS 23 West "B" | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Clarence Middle Hamilton Last Foster | | | | 4. DATE OF DEATH Month 3 Day 23 Year 60 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1-7-1899 | |
| 9. AGE (In years less birthday) 61 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | | 11. IF UNDER 24 HRS. Months Days Hours Min. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Conductor | | | | 10b. KIND OF BUSINESS OR INDUSTRY B.&O.R.R.Co | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Charles Foster | | | | 14. MOTHER'S MAIDEN NAME Annie Mewshaw | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) INFORMANT Mrs. Bessie V. Foster, Brunswick, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor Pulmonale 420.1 DUE TO Decompensated Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Right Post-Pneumonia Hydrothorax DUE TO (c) Coronary Insufficiency | | | | | | INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 1 yr. 2 wks. 3 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State) | |
| 21. I certify that I attended the deceased from Dec. 30, 1957 to March 23, 1960 , that I last saw the deceased alive on March 23, 1960 and that death occurred at 6 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 15 S. Maryland Ave. DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE C. T. Byron Kao, M. D. | | | | PHYSICIAN'S NAME (Type) Brunswick, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3-26-1960 | | 22c. NAME OF CEMETERY OR CREMATORY Union | | 22d. LOCATION (City, town, or county) (State) Lovettsville, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE B. Lee Felt | | | | ADDRESS Brunswick, Maryland | | 24a. REC'D BY REGISTRAR DATE MAR 28 '60 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur L. Hume | | | |

MEDICAL CERTIFICATION

113308

CERTIFICATE OF DEATH

2004



Discharge - Death

1. Name of deceased

2. Date of death

1

3. Cause of death
4. Place of death
5. Signature of attending physician
6. Signature of registrar
7. Date of registration

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3275

CERTIFICATE OF DEATH

Reg. Dist. No.

03253

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | c. LENGTH OF STAY IN 1b 6 yrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 109 West Third Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First ELLA Middle ESTELLE Last FRY | | 4. DATE OF DEATH Month March Day 2 Year 1960 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH February 4, 1874 |
| 9. AGE (In years last birthday) 86 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work | | 10b. KIND OF BUSINESS OR INDUSTRY Domestic | |
| 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Joshua C. Fry | | 14. MOTHER'S MAIDEN NAME Maria Stout | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None | |
| 17. INFORMANT Miss M. Blanche Fry, (same as item #2) | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x DUE TO Cerebral thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Senility (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 weeks 2 years | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Feb 2-29, 1960 to 3-2-1960 that I last saw the deceased alive on 7:40 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 220 North Market St. DATE SIGNED 3/3/60 | | | |
| ACTUAL SIGNATURE R. R. Martin | | M.D. Frederick, Maryland | |
| PHYSICIAN'S NAME (Type) Dr. Rex R. Martin | | Frederick, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3/4/60 | |
| 22c. NAME OF CEMETERY OR CREMATORY Union Cemetery | | 22d. LOCATION (City, town, or county) (State) Lovettsville, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son; Frederick, Maryland | | ADDRESS | |
| 24a. REC'D BY REGISTRAR DATE MAR 8 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Martin | |

3277

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b Life-Time d. NAME OF HOSPITAL (If not in hospital, give street address) 243 South Market Street | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS 243 South Market Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First WILLIAM Middle STEINER Last GOSNELL | | | | 4. DATE OF DEATH Month March Day 28 Year 19 60 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 11 June 1881 | |
| 9. AGE (In years last birthday) 78 yrs. | | IF UNDER 1 YEAR Months 78 Days 78 Hours 78 Min. | | IF UNDER 24 HRS. Months 78 Days 78 Hours 78 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Combination Man | | | | 10b. KIND OF BUSINESS OR INDUSTRY Telephone Company | | 11. BIRTHPLACE (State or foreign country) Frederick, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME Stewart Gosnell | | | | 14. MOTHER'S MAIDEN NAME Catherine Haugh | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. 212-05-0806 | | INFORMANT Address Mrs. Margaret D. Gosnell (Same as item #1) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral arteriosclerosis 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 11/10 , 19 59 , to 3/28 , 19 60 , that I last saw the deceased alive on 3/28 , 19 60 , and that death occurred at 9:38P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9 E. Church St. Frederick, Md. DATE SIGNED 30 March 1960 ACTUAL SIGNATURE Richard C. Reynolds, M.D. PHYSICIAN'S NAME (Type) Richard C. Reynolds, M. D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3-31-60 | | 22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | | 22d. LOCATION (City, town, or county) (State) Frederick, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS M. R. Etchison & Son, Frederick, Maryland | | | | 24a. REC'D BY REGISTRAR DATE APR 1 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Howard | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

88251

CERTIFICATE OF DEATH

3277

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Usual residence: _____

7. Cause of death: _____

8. Date of death: _____

9. Time of death: _____

10. Signature of physician: _____

11. Signature of registrar: _____

12. Date of registration: _____

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03255

3310

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|-------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Myersville c. LENGTH OF STAY IN 1b 30 months d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route # 1 | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Myersville d. STREET ADDRESS Route # 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First BENJAMIN Middle SAMEUL Last GOUKER | | 4. DATE OF DEATH Month March Day 31 Year 1960 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 3, 1884 |
| 9. AGE (In years lost birthday) 75 | | 10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Road Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Fred.Co.Road Dept | |
| 11. BIRTHPLACE (State or foreign country) Frederick Co. Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Curtis Gouker | | 14. MOTHER'S MAIDEN NAME Annie E. Traver | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 216-05-9216 | |
| 17. INFORMANT Mr. Elmer B. Gouker, Myersville, Md. | | Address Myersville, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 5 Yrs. | | INTERVAL BETWEEN ONSET AND DEATH 5 Yrs. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 10/24 , 1957 , to 3/31 , 1960 , that I last saw the deceased alive on 3/20 , 1960 , and that death occurred at 11:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3-31-60 DATE SIGNED | | | |
| ACTUAL SIGNATURE Charles F. Hess M.D. | | DATE SIGNED 3-31-60 | |
| PHYSICIAN'S NAME (Type) Charles F. Hess | | Smihsburg, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF April 2, 1960 | |
| 22c. NAME OF CEMETERY OR CREMATORY Grossnickle's | | 22d. LOCATION (City, town, or county) (State) Nr. Myersville, Fred. Co. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Paul F. Bittle, Myersville, Md. | | 24a. REC'D BY REGISTRAR APR 5 '60 | |
| ADDRESS Myersville, Md. | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

68302

CERTIFICATE OF DEATH

3310

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CLERGYMAN

NAME OF CLERGYMAN

NAME OF CLERGYMAN

NAME OF CLERGYMAN

CERTIFICATE OF DEATH

Reg. Dist. No.

03256

3296

| | | | |
|---|---------------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick | | c. LENGTH OF STAY IN 1b Life | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 26 East "F" | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Emory Middle Hamilton Last Hahn | | 4. DATE OF DEATH Month 3 Day 23 Year 1960 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-15-1893 |
| 9. AGE (In years last birthday) 67 yrs. | | 10. IF UNDER 1 YEAR Months 3 Days 23 Hours 19 Min. | 11. IF UNDER 24 HRS. Months 3 Days 23 Hours 19 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Town of Bswk. | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charles Henry Hahn | | 14. MOTHER'S MAIDEN NAME Jennie Hamilton | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. INFORMANT Mrs. Lillie M. Hahn, Brunswick, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Valvular Heart Disease 421.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 3 yrs | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 11/24 , 19 59 to 3/23 , 19 60 that I last saw the deceased alive on 3/22 , 19 60 , and that death occurred at 12:00 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE J.G.F. Smith | | M.D. James H. Smith ADDRESS (Street, city or town, state) Brunswick, Maryland DATE SIGNED 3/23/60 | |
| PHYSICIAN'S NAME (Type) J.G.F. Smith | | Brunswick, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 3-25-1960 | 22c. NAME OF CEMETERY OR CREMATORY Park Heights | 22d. LOCATION (City, town, or county) (State) Brunswick, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE B. Lee Felt | | ADDRESS Brunswick, Maryland | |
| 24a. REC'D BY REGISTRAR MAR 28 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Hanes | |

03256

CERTIFICATE OF DEATH

1925

PROLONGED

1925

1925

1925

1925

1925

1925

[Handwritten signature]

[Handwritten signature]

1925

1925

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03257

3311 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|---|---|---|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Ladiesburg | | | | c. LENGTH OF STAY IN 1b 21 years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Vertie Middle Anna Mary Last Hahn | | | | 4. DATE OF DEATH Month March Day 9 Year 19 60 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH December 7, 1881 | 9. AGE (In years last birthday) 78 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Albert Shoemaker | | | | 14. MOTHER'S MAIDEN NAME Amanda Eyler | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 213-01-3184B | | INFORMANT Address Mr. Charles F. Hahn, Ladiesburg, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH sudden | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that I attended the deceased from 2-16 , 19 60 , to 3-9 , 19 60 that I last saw the deceased alive on 2-7 , 19 60 , and that death occurred at 7 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE J. N. Legg | | M.D. William B. Brown | | ADDRESS (Street, city or town, state) Ladiesburg, Md. | | DATE SIGNED 3-11-60 | |
| PHYSICIAN'S NAME (Type) T. H. LEGG | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Mar. 12, 1960 | 22c. NAME OF CEMETERY OR CREMATORY Haugh's Church Cemetery | | 22d. LOCATION (City, town, or county) (State) Ladiesburg, Frederick, Maryland | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE C. O. Fuss & Son ADDRESS C. O. Fuss & Son, Taneytown, Md. | | | | 24a. REC'D BY REGISTRAR DATE MAR 14 '60 | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | | |

63521

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

Form with multiple lines for text entry, including fields for name, date, and location. The text is faint and mostly illegible.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03258

3312

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown | | c. LENGTH OF STAY IN 1b years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Elva Middle Mae Last Hoffman | | 4. DATE OF DEATH Month 3 Day 12 Year 1960 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5/26/1925 |
| 9. AGE (In years last birthday) 34 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) bookkeeper | | 10b. KIND OF BUSINESS OR INDUSTRY newspaper office | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME George A. Bidle | | 14. MOTHER'S MAIDEN NAME Goldie Guyton | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 215-20-9491 | |
| 17. INFORMANT Harold H. Hoffman, Middletown, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma right Breast 1956 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) metastasis to vertebra, femur & lungs DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (mastectomy performed in 1956) | | INTERVAL BETWEEN ONSET AND DEATH 4 yrs | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Mar 12 , 19 58 , to Mar 12 , 19 60 , that I last saw the deceased alive on Mar 12 , 19 60 , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Middletown 3-14-60 | | | |
| ACTUAL SIGNATURE J Elmer Harp M.D. | | PHYSICIAN'S NAME (Type) Dr. J. Elmer Harp Middletown, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 22b. DATE THEREOF 3/15/1960 | |
| 22c. NAME OF CEMETERY OR CREMATORY U.B. Cemetery | | 22d. LOCATION (City, town, or county) (State) Myersville, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md. | | ADDRESS Middletown, Md. | |
| 24a. REC'D BY REGISTRAR DATE MAR 16 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

85298

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

CERTIFICATE OF DEATH

3318

5

1

CERTIFICATE OF DEATH

Reg. Dist. No.

03259

3297

| | | | |
|--|---------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Frederick</u> <u>9999999999</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brunswick</u> | | c. LENGTH OF STAY IN 1b <u>Life</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>203 West "B"</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle <u>Virginia</u> Last <u>Hovermale</u> | | 4. DATE OF DEATH Month <u>3</u> Day <u>15</u> Year <u>1960</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8-22-1867</u> |
| 9. AGE (In years last birthday) <u>92</u> yrs. | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | 11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>WEST VIRGINIA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>William Michael</u> | | 14. MOTHER'S MAIDEN NAME <u>Josephine Widnyer</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u> </u> | |
| 17. INFORMANT <u>Mr. Charles W. Hovermale, Brunswick, Md.</u> | | Address <u> </u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure</u> DUE TO (c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH <u>14 hours</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>March 7, 1960</u> to <u>March 15, 1960</u> , that I last saw the deceased alive on <u>March 15, 1960</u> , and that death occurred at <u>5:15 AM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>C. T. Byron Kao</u> M.D. | | DATE SIGNED <u>15 S. Maryland Ave.</u> | |
| PHYSICIAN'S NAME (Type) <u>C. T. Byron Kao, M. D.</u> | | <u>Brunswick, Maryland</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>3-18-1960</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Park Heights</u> | 22d. LOCATION (City, town, or county) (State) <u>Brunswick, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Frank</u> | | ADDRESS <u>Brunswick, Maryland</u> | |
| 24a. REC'D BY REGISTRAR <u>MAR 21 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u> | |

10552

CERTIFICATE OF DEATH

1931

11

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

STATE OF MASSACHUSETTS
COUNTY OF _____
CITY OF _____

BEFORE ME, the undersigned authority, on this _____ day of _____, 19____, personally appeared _____, known to me to be the person whose name is subscribed to the foregoing certificate of death, and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this _____ day of _____, 19____.

Notary Public for the County of _____, State of Massachusetts.

CERTIFICATE OF DEATH

Reg. Dist. No.

3278

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | c. LENGTH OF STAY IN 1b over 35 years | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | d. STREET ADDRESS 509 Lee Place | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 509 Lee Place | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Grace Middle Corbitt Last Keyes | | 4. DATE OF DEATH Month March Day 15 Year 19 60 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH August 16, 1887 |
| 9. AGE (In years last birthday) 72 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Music Teacher | | 10b. KIND OF BUSINESS OR INDUSTRY None | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME George Andrew Bishop Zimmerman | | 14. MOTHER'S MAIDEN NAME Ida Belle Corbitt | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 214-34-0815 | |
| INFORMANT Miss Dorothy E. Keys | | Address 509 Lee Place | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of breast 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 18 Mos | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Sept 29, 1958 to March 15, 1960 , that I last saw the deceased alive on March 15, 1960 , and that death occurred at 6:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) March 15, 1960 | | | |
| ACTUAL SIGNATURE S. Schoorman M.D. | | DATE SIGNED March 15, 1960 | |
| PHYSICIAN'S NAME (Type) Dr. L. R. Schoorman M.D. | | 228 North Market St. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3-18-1960 | |
| 22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | | 22d. LOCATION (City, town, or county) (State) Frederick, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert E. Dailey Jr. | | 24a. REC'D BY REGISTRAR DATE MAR 16 '60 | |
| ADDRESS Frederick, Maryland | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100000

CENTRAL STATE OF DEATH

100000



100000

100000



3313 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#7 c. LENGTH OF STAY IN 1b Since 5-12-58 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montevue (County Home) | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS 411 Klineharts Alley e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First GEORGE Middle EDWARD Last KINTZ | | 4. DATE OF DEATH Month March Day 20 Year 1960 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10 Sept 1879 |
| 9. AGE (In years last birthday) 80 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Laborer | 11. BIRTHPLACE (State or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME David Kintz | |
| 14. MOTHER'S MAIDEN NAME Ida Whipp | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. Unk | | 17. INFORMANT Address Harry Kintz, RD#1, Adamstown, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH 2 yrs. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from May 12 , 19 58 , to Mar 12 , 19 60 , that I last saw the deceased alive on Mar 12 , 19 60 , and that death occurred at 5:30 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7 N. Market St. Frederick, Md. DATE SIGNED 21 March 1960 ACTUAL SIGNATURE H. F. Kline PHYSICIAN'S NAME (Type) H. F. Kline, M. D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 3-23-60 | 22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | 22d. LOCATION (City, town, or county) (State) Frederick, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS M. R. Etchison & Son, Frederick, Maryland | | 24a. REC'D BY REGISTRAR DATE MAR 23 '60 | 24b. REGISTRAR'S SIGNATURE Orin G. Kline |

1

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

105501

CERTIFICATE OF DEATH

3313



Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.

NAME: _____

DATE: _____

LOCATION: _____

CAUSE OF DEATH: _____

SIGNATURE: _____



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3314 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03262

Reg. Dist. No.

| | | | | | | | | | |
|---|--|--|---|---|---|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burkittsville</u> years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burkittsville</u> d. STREET ADDRESS | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Sarah Ella Little</u> | | | | 4. DATE OF DEATH Month Day Year <u>3 14 19 60</u> | | | | | |
| 5. SEX <u>female</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>9/9/1870</u> | | 9. AGE (In years last birthday) <u>89</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | |
| 13. FATHER'S NAME <u>(unknown) Young</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Savilla King</u> | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT <u>Fred. Co. Welfare Records</u> Address | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>bronchial pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>exposure</u> (c), stating the underlying cause last. DUE TO | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE <u>B. O. Thomas</u> M.D. | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>Dr. B. O. Thomas</u> | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | | | DATE SIGNED <u>3/14/1960</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> | | 22b. DATE THEREOF <u>3/17/1960</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Locust Valley Ch. of G. Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Frederick Co., Md.</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Company, Middletown, Md.</u> ADDRESS | | | | | | 24a. REC'D BY REGISTRAR <u>MAR 18 '60</u> DATE | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained to your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

13: MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| <p>1. NAME OF DECEASED: _____</p> | | <p>2. SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female</p> | |
| <p>3. AGE: _____</p> | | <p>4. DATE OF BIRTH: _____</p> | |
| <p>5. PLACE OF BIRTH: _____</p> | | <p>6. OCCUPATION: _____</p> | |
| <p>7. MARITAL STATUS: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced</p> | | <p>8. EDUCATION: _____</p> | |
| <p>9. PRESENT ADDRESS: _____</p> | | <p>10. DATE OF DEATH: _____</p> | |
| <p>11. CAUSE OF DEATH: _____</p> | | <p>12. MANNER OF DEATH: <input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal</p> | |
| <p>13. SIGNATURE OF EXAMINER: _____</p> | | <p>14. SIGNATURE OF WITNESS: _____</p> | |
| <p>15. DATE OF SIGNATURE: _____</p> | | <p>16. PLACE OF SIGNATURE: _____</p> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO MEDICAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3315

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03263

Reg. Dist. No.

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Myersville</u> | c. LENGTH OF STAY IN 1b <u>1 month</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural Middletown</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS <u>1</u> | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>Huey</u> Middle <u>P.</u> Last <u>Long</u> | | 4. DATE OF DEATH Month <u>3</u> Day <u>28</u> Year <u>19 60</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9/7/1935</u> |
| 9. AGE (In years last birthday) <u>24</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farm laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u> | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | | |
| 13. FATHER'S NAME <u>Leslie H. Long</u> | | 14. MOTHER'S MAIDEN NAME <u>Nellie Routzahn</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>217-32-7223</u> | |
| 17. INFORMANT <u>Leslie H. Long, Middletown, Md.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>self-inflicted gunshot wound of skull</u> <u>976X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>4:30</u> o. m. <u>pm</u> <u>3 / 28 / 60</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rural Myersville, Fred. co.</u> |
| 20f. (City or town) <u>Md.</u> | | (County) <u>Fred. co.</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Noturol causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined monner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>B O Thomas</u> | | M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>Dr. B. O. Thomas</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED <u>3/28/1960</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> | | 22b. DATE THEREOF <u>3/30/1960</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u> |
| 22d. LOCATION (City, town, or county) <u>Middletown, Md.</u> | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Company, Middletown, Md.</u> | | 24a. REC'D BY REGISTRAR <u>MAR 31 '60</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krawe</u> | | | |

43503

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3316

FOR STATE
HEALTH OFFICE

NO

4

1900

DATE OF DEATH

TIME

PLACE

CAUSE

OTHER

Form with multiple sections for medical examination, including fields for name, age, sex, race, occupation, and cause of death. The form is divided into several columns and rows, with checkboxes and lines for text entry. The text is mirrored and appears to be a bleed-through from the reverse side of the page.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 8 Film G259 3-28-60 et
3316
CERTIFICATE OF DEATH

03264

Reg. Dist. No.

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Unionville | | c. LENGTH OF STAY IN 1b 35 yrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) LEONA First Middle Last | | 4. DATE OF DEATH March 16, 1960 Month Day Year | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1885 19 December 31, 60 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) 74 yrs. |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Thomas Long | | 14. MOTHER'S MAIDEN NAME Martha Black | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. 216-22-9845 | |
| 17. INFORMANT Myrthe Long | | Address Same | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH 5 days 5 years |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from June 1955 to March 1960 , that I last saw the deceased alive on March 16, 1960 , and that death occurred at 11 P. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE W. B. Culwell M.D. | | ADDRESS (Street, city or town, state) 900 So. Main DATE SIGNED 3/17/60 | |
| PHYSICIAN'S NAME (Type) W. B. Culwell M.D. | | Mt. Airy, Md | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 3-21-1960 | 22c. NAME OF CEMETERY OR CREMATORY Linganore Cemetery | 22d. LOCATION (City, town, or county) (State) Frederick Co. Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE C. M. WALTZ, Winfield, Maryland | | 24a. REC'D BY REGISTRAR DATE MAR 22 '60 | |
| | | 24b. REGISTRAR'S SIGNATURE William S. Kraus | |

3279

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH o. COUNTY FREDERICK MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY Fred. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RURAL FREDERICK, Route # 2 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First HELEN Middle VIRGINIA Last MAIN | | 4. DATE OF DEATH Month March Day 26 Year 1960 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 1, 1915 |
| 9. AGE (In years last birthday) 44 yrs. | | 10. IF UNDER 1 YEAR Months 4 Days 1 Hours 1 Min. | 11. IF UNDER 24 HRS. Months 4 Days 1 Hours 1 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Homemaker | |
| 11. BIRTHPLACE (State or foreign country) Frederick County Md. | | 12. CITIZEN OF WHAT COUNTRY? USA. | |
| 13. FATHER'S NAME Elmer Shelton | | 14. MOTHER'S MAIDEN NAME Mary Siers. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 215-14-2578 | |
| 17. INFORMANT Mar. Hattie Shelton | | Address Frederick Rt # 2. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Acute Coronary Heart Failure DUE TO (b) Cerebral Vascular Accident. DUE TO (c) lying cause lost. | | | INTERVAL BETWEEN ONSET AND DEATH 2 sec 5 m |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 3-24 , 19 60 , to 3-26 , 19 60 , that I last saw the deceased alive on 3-25 , 19 60 , and that death occurred at 10:35 M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE U. G. Bourne Jr. M.D. | | ADDRESS (Street, city or town, state) Frederick Md. 3-26-60 | |
| PHYSICIAN'S NAME (Type) U. G. Bourne | | 30, All Saints St., Frederick, Maryland. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 3/29/60 | 22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery | 22d. LOCATION (City, town, or county) (State) Frederick, Maryland. |
| 23. FUNERAL DIRECTOR'S SIGNATURE DAILEY'S FUNERAL HOME | | 24a. REC'D BY REGISTRAR DATE MAR 30 '60 | |
| ADDRESS FREDERICK, MARYLAND, | | 24b. REGISTRAR'S SIGNATURE Arthur L. Kneass | |

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

08302

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

CERTIFICATE OF DEATH

3252



Form with multiple lines for text entry, including fields for name, date, and location. The text is faint and mostly illegible due to the quality of the scan. Some visible text includes "Name", "Date", and "Place".

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03266

3280

FOR STATE
HEALTH DEPT.

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH o. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | c. LENGTH OF STAY IN 1b Hour | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First FRANK Middle JEROME Last McCLAIN | | 4. DATE OF DEATH Month March Day 9 Year 19 60 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH August 5, 1903 |
| 9. AGE (In years last birthday) 56 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) County Rd. Dept. | | 10b. KIND OF BUSINESS OR INDUSTRY Grader Operator | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Joseph McClain | | 14. MOTHER'S MAIDEN NAME Katherine Pearre | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 216-14-6781 | |
| 17. INFORMANT Mrs. Frances Irene McClain-Same as item #2 | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE B. O. Thomas | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) B. O. Thomas, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| DATE SIGNED 3/11/1960 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Mar. 12, 1960 | |
| 22c. NAME OF CEMETERY OR CREMATORY Methodist Cemetery | | 22d. LOCATION (City, town, or county) (State) Hyattstown, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. L. Burdette, Hyattstown, Maryland | | 24a. REC'D BY REGISTRAR DATE MAR 14 '60 | |
| | | 24b. REGISTRAR'S SIGNATURE Carlton S. Kraus | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. Page 5 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

103266

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, date, time, place, and cause of death. The form is oriented horizontally but contains vertical text labels for various fields.

NAME: [Blank]
DATE: [Blank]
TIME: [Blank]
PLACE: [Blank]
CAUSE OF DEATH: [Blank]
MANNER OF DEATH: [Blank]
SEX: [Blank]
AGE: [Blank]
RACE: [Blank]
OCCUPATION: [Blank]
EDUCATION: [Blank]
RELIGION: [Blank]
MARRIAGE: [Blank]
CHILDREN: [Blank]
SIBLINGS: [Blank]
PARENTS: [Blank]
GRANDPARENTS: [Blank]
BROTHERS: [Blank]
SISTERS: [Blank]
AUNT: [Blank]
UNCLE: [Blank]
Nephew: [Blank]
Niece: [Blank]
Cousin: [Blank]
In-law: [Blank]
Other: [Blank]

CERTIFICATE OF DEATH

Reg. Dist. No.

03267

3317

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH o. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-R.F.D.#5 | | c. LENGTH OF STAY IN 1b Years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Braddock Heights | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First JOHN Middle HERMAN Last MOCK | | 4. DATE OF DEATH Month March Day 12 , Year 1960 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 20, 1890 |
| 9. AGE (In years last birthday) yrs. 69 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Building Contrator | | 10b. KIND OF BUSINESS OR INDUSTRY Building | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William T. Mock | | 14. MOTHER'S MAIDEN NAME Elizabeth F. Wise | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 214-14-6674 | |
| 17. INFORMANT Mrs. Edna R. Mock- Same as Item #2 | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours 21 years | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Oct , 19 39 , to March 12 , 19 60 , that I last saw the deceased alive on March 12 , 19 60 , and that death occurred at 6:30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Professional Building DATE SIGNED 3/14/1960 ACTUAL SIGNATURE L. R. Schoolman M.D. PHYSICIAN'S NAME (Type) L. R. Schoolman, M.D. Frederick, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Mar. 15, 1960 | |
| 22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | | 22d. LOCATION (City, town, or county) (State) Frederick, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE M.R. Etchison & Son, Frederick, Maryland | | 24a. REC'D BY REGISTRAR DATE MAR 15 '60 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

03807

CENTRAL OFFICE

331

THE OFFICE OF THE
DIRECTOR OF THE
BUREAU OF THE
CENSUS
WASHINGTON, D. C.
JULY 20, 1907
SIR,
I have the honor to acknowledge the receipt of your letter of the 17th inst. in relation to the matter of the
Bureau of the Census, and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.
Very respectfully,
J. W. COOPER, Director

3299

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emmitsburg, | | | | c. LENGTH OF STAY IN 1b 35 years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) East Main Street | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First George Middle Calvin Last Naylor | | | | 4. DATE OF DEATH Month March Day 28 Year 19 60 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Oct. 30, 1873 | |
| 9. AGE (In years last birthday) 86 yrs. | | IF UNDER 1 YEAR Months 28 Days 19 Hours 60 Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY York Springs, Pa. | |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Henry A. Naylor | | | | 14. MOTHER'S MAIDEN NAME Margaret L. RHODES | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 219-20-1054 | | 17. INFORMANT H. Miller Naylor Address Taneytown, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial failure - 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) myocardial degeneration DUE TO (c) arterio sclerotic C.V. disease - 422.1 DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (b) 5 yrs INTERVAL BETWEEN ONSET AND DEATH 1 day | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour 19 o. ft. p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) Emmitsburg, Md. | | | | 20g. (County) Frederick | | | |
| 20h. (State) Md. | | | | 20i. (Country) U.S.A. | | | |
| 21. I certify that I attended the deceased from Dec 26, 1960 to March 27, 1960 , that I last saw the deceased alive on March 27, 1960 , and that death occurred at 4 A. M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE W. R. Cadle | | | | M.D. Emmitsburg, Md. | | | |
| PHYSICIAN'S NAME (Type) Dr. W. R. Cadle | | | | ADDRESS Emmitsburg, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3/30/60 | | 22c. NAME OF CEMETERY OR CREMATORY Keyville Cemetery | | 22d. LOCATION (City, town, or county) (State) Keyville, Md. Carroll Co. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE C. E. Wilson | | | | ADDRESS Emmitsburg, Md. | | 24a. REC'D BY REGISTRAR DATE MAR 31 '60 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Hines | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03269

3281

| | | | | | | | |
|---|------------------------------|---|---------------------------------|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | | c. LENGTH OF STAY IN 1b // Frederick | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memoria l Hospital | | | | d. STREET ADDRESS 400 Middle Alley | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Harriet Cornelious Naylor Middle (Hattie) Last 4. DATE OF DEATH Month March Day 2 Year 1960 | | | | | | | |
| 5. SEX F | 6. COLOR OR RACE C | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1909 | 9. AGE (In years lost birthday) 51 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10b. KIND OF BUSINESS OR INDUSTRY ***** | | 11. BIRTHPLACE (State or foreign country) Frederick-Co. Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Henry Naylor | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. Unknown | | INFORMANT Address Fred. Md. Nellie Holland-15 W. All Saints St. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 DUE TO Cirrhosis Liver (Hepatic Coma) Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 years 1 day. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Feb 20 , 19 60 , to March 2 , 19 60 that I last saw the deceased alive on March 2 , 19 60 , and that death occurred at 8 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Bernard O. Thomas Jr M.D. Frederick, Md March 7, 60 | | | | | | | |
| ACTUAL SIGNATURE Bernard O. Thomas Jr | | | | PHYSICIAN'S NAME (Type) BERNARD O. THOMAS, JR. FREDERICK, MARYLAND | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3-8-60 | | 22c. NAME OF CEMETERY OR CREMATORY St. Pauls | | 22d. LOCATION (City, town, or county) (State) Della-Fred. Co. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE C.E. Hicks 111 | | | | ADDRESS Frederick-Md. | | 24a. REC'D BY REGISTRAR MAR 11 1960 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas | | | |

103288

CERTIFICATE OF DEATH

1904

Proctorick

Proctorick

Proctorick

Proctorick, Samuel J. (born 1844)

Proctorick, Samuel J. (born 1844)

1844

Proctorick

Proctorick, Samuel J. (born 1844)

John Henry Proctorick

No

Proctorick, Samuel J. (born 1844)

Proctorick, Samuel J. (born 1844)

Proctorick, Samuel J. (born 1844)

Proctorick, Samuel J. (born 1844)

Proctorick, Samuel J. (born 1844)

Proctorick, Samuel J. (born 1844)

Proctorick, Samuel J. (born 1844)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03270

3300

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emmitsburg, | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emmitsburg, | | | |
| c. LENGTH OF STAY IN 1b 35 years | | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION East Main Street | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Maud Middle Estelle Last Naylor | | | | 4. DATE OF DEATH Month March Day 27 Year 19 60 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Dec. 27, 1878 | |
| 9. AGE (In years last birthday) yrs. 81 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 11. BIRTHPLACE (State or foreign country) Frederick Co. Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Benjamin R. Stull | | | | 14. MOTHER'S MAIDEN NAME Estelle Whitmore | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT St Wilbur Naylor Address Taneytown Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral hemorrhage 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio & sclerotic cardio Vas disease several years DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from Dec 26 , 19 60 to March 27 , 19 60 , that I last saw the deceased alive on March 27 , 19 60 , and that death occurred at 1:30 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Emmitsburg, Md. DATE SIGNED March 28, 60 | | | | | | | |
| ACTUAL SIGNATURE W R Cadle M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) Dr. W. R. Cadle | | | | Emmitsburg, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3/30/1960 | | 22c. NAME OF CEMETERY OR CREMATORY Keysville Cemetery | | 22d. LOCATION (City, town, or county) (State) Md. Keysville, Md. Carroll Co. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE C. E. Wilson ADDRESS Emmitsburg, Md. | | | | 24a. REC'D BY REGISTRAR DATE MAR 31 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

C. E. Wilson

13250

CERTIFICATE OF DEATH

| | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|
| DECEASED NAME JAMES H. HARRIS | | SEX Male | | AGE 45 Years | | RACE White | | OCCUPATION Carpenter | |
| PLACE OF BIRTH Baltimore, Md. | | DATE OF BIRTH Nov. 27, 1898 | | PLACE OF DEATH Baltimore, Md. | | DATE OF DEATH Dec. 1, 1943 | | TIME OF DEATH 10:30 A.M. | |
| CAUSE OF DEATH Myocardial Infarction | | DISEASE OR INJURY None | | MANNER OF DEATH Natural | | PLACE OF INTERMENT St. Paul's Cemetery | | DATE OF INTERMENT Dec. 3, 1943 | |
| SIGNATURE OF DECEASED (None) | | SIGNATURE OF NEXT OF KIN J. H. Harris | | SIGNATURE OF PHYSICIAN J. H. Harris | | SIGNATURE OF CLERK J. H. Harris | | SIGNATURE OF REGISTRAR J. H. Harris | |
| SIGNATURE OF DECEASED (None) | | SIGNATURE OF NEXT OF KIN J. H. Harris | | SIGNATURE OF PHYSICIAN J. H. Harris | | SIGNATURE OF CLERK J. H. Harris | | SIGNATURE OF REGISTRAR J. H. Harris | |



THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD. IT IS TO BE RETURNED TO THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD. WITHIN 10 DAYS OF THE DATE OF DEATH.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03271

3282

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u> | | | | c. LENGTH OF STAY IN 1b <u>10 hrs 35 min</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FREDERICK Memorial Hospital</u> | | | | e. STREET ADDRESS <u>FREDERICK Maryland</u> | | f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Kenneth</u> Middle <u>Wayne</u> Last <u>Palm</u> | | | | 4. DATE OF DEATH Month <u>MARCH</u> Day <u>13</u> Year <u>1960</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>N</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>MARCH 13, 1960</u> | |
| 9. AGE (In years last birthday) yrs. <u>10</u> | | 10. IF UNDER 1 YEAR Months <u>10</u> Days <u>35</u> | | 11. IF UNDER 24 HRS. Hours <u>10</u> Min. <u>35</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 13. FATHER'S NAME <u>SAMUEL RAY PALM</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MILDRED WHITING NAYLOR</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT Address <u>MOTHER 153 W. ALL SAINTS ST.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>434.1</u> IMMEDIATE CAUSE (a) <u>Coronary Heart Failure, cause unmet.</u> DUE TO (b) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u> DUE TO (c) <u>—</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u> | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u> | |
| 20f. (City or town) <u>—</u> | | | | 20g. (County) <u>—</u> | | 20h. (State) <u>—</u> | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>13 March 1960</u> , to <u>13 March 1960</u> , that (I) (we) last saw the deceased alive on <u>13 March 1960</u> , and that death occurred at <u>1:28 PM</u> , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>A. M. Powell Jr.</u> | | | | 22b. DATE SIGNED <u>13 March 1960</u> | | 22c. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (Type) <u>A. M. Powell Jr.</u> | | | | 22e. ADDRESS <u>FREDERICK-MEDICAL-CENTER Maryland</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>MAR 15-60</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW</u> | | 23d. LOCATION (City, town, or county) (State) <u>FREDERICK-MD</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Hicks III</u> | | | | 24a. ADDRESS <u>FREDERICK-MD</u> | | 24b. REC'D BY REGISTRAR DATE <u>MAR 17 '60</u> | |
| 24c. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u> | | | | 24d. REGISTRAR'S SIGNATURE <u>—</u> | | | |

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 2 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3318 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03272

| | | | | | |
|--|---|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural-R.D.#5 | | c. LENGTH OF STAY IN 1b 2 Years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick Rural -R.F.D.#5 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Fulmer Road | | | d. STREET ADDRESS Fulmer Road | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First ARCHIE Middle LEE Last PEARSON | | | 4. DATE OF DEATH Month March Day 25 Year 1960 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH January 1, 1892 | | 9. AGE (In years last birthday) 68 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Own Farm | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | 13. FATHER'S NAME Unknown | | |
| 14. MOTHER'S MAIDEN NAME Unknown | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WWI | | |
| 16. SOCIAL SECURITY NO. 216-12-4613 | | | 17. INFORMANT Mrs. Viola M. Davis, 333 South Market Street, Frederick, Maryland | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) EXPOSED EXPOSURE DUE TO (c) _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH Minutes ? |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE B. O. Thomas M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) B. O. Thomas, Md. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | March 25, 1960 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Mar. 28, 1960 | | 22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | |
| 22d. LOCATION (City, town, or county) Frederick, Maryland | | 22e. LOCATION (State) Maryland | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | | 24a. REC'D BY REGISTRAR MAR 29 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus |

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
Items 11,12

CERTIFICATE OF DEATH

Film G259, 3/24/60lb

03273

3283

| | | | |
|---|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>N. YORK</u> b. COUNTY <u>MONROE</u> ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u> | | c. LENGTH OF STAY IN 1b <u>2 HRS</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>FREDERICK MEMORIAL HOSP</u> | | d. STREET ADDRESS <u>212 EDGEWOOD AVE</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Raymond J Plant</u> | | 4. DATE OF DEATH Month Day Year <u>March 20 1960</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>NOV. 30, 1893</u> |
| 9. AGE (In years last birthday) <u>66</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>LIFE INSURANCE</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>New York City</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>JOSEPH PLANT</u> | | 14. MOTHER'S MAIDEN NAME <u>MARY MAHONEY</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Mrs. Joseph PLANT</u> | | Address <u>ROCHESTER N.Y.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2 hr.</u> <u>10 yrs +</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>3/19</u> 19 <u>60</u> , to <u>3/20</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>3/20</u> 19 <u>60</u> , and that death occurred at <u>3A</u> M., from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Henry V. Chase</u> | | 22b. DATE SIGNED <u>3/20/60</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u> | | 22d. ADDRESS <u>4 E. Church St. Frederick, Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> | | 23b. DATE THEREOF <u>3/24/60</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>HOLY SEPULCHER</u> | | 23d. LOCATION (City, town, or county) (State) <u>ROCHESTER N.Y</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Clarence C. Early</u> | | 25a. REC'D BY REGISTRAR <u>Frederick</u> DATE <u>MAR 21 '60</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | | | |

1933



CERTIFICATE OF DEATH

1933

Blank certificate form with horizontal lines for text entry.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03274

3284

| | | | | | | | |
|---|----------------------------------|---|--|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | | c. LENGTH OF STAY IN 1b 5 weeks 3 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Frederick Memorial Hosiptal | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First EDWARD Middle F Last PLUMER | | | | 4. DATE OF DEATH Month 3 - Day 15 Year 1960 | | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 29, 1887 | | 9. AGE (In years last birthday) yrs. 72 | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Own Farm | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Frederick Plumer | | | | 14. MOTHER'S MAIDEN NAME Margaret Snyder | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 217-12-1801 | | 17. INFORMANT Louis Plumer Address Thurmont, Md. RFD | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thromboses 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH 36 days years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 2/6 19 60 , to 3/15 19 60 , that (I) (we) last saw the deceased alive on 3/15 19 60 and that death occurred at 11:30 AM, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Richard C. Reynolds | | | | 22b. DATE 3/16/60 | | 22c. PHYSICIAN'S NAME (Type) Richard C. Reynolds | |
| 22d. ADDRESS 9 E. Church St. Frederick, Md. | | | | 22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 3-18-60 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery | | 23d. LOCATION (City, town, or county) (State) Thurmont, Md. Fred. Co. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Cramer | | | | 25a. REC'D BY REGISTRAR DATE MAR 21 '60 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |



Frederick

Maryland

St. Louis

Frederick

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Frederick Memorial Hospital

Frederick

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Dec. 29, 1987

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219-12-1001 weeks tumor

Frederick, Md.



Richard O. ...

Frederick Memorial Hospital

Frederick

Frederick, Md.

Frederick, Md.

Frederick, Md.

3319

CERTIFICATE OF DEATH

Reg. Dist. No.

03275

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|---|--|--|--|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont rural | | | | c. LENGTH OF STAY IN 1b 30 yrs | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Own Home | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Elizabeth M. Middle Plumer Last | | | | 4. DATE OF DEATH Month March Day 1 Year 1960 | | | |
| 5. SEX Female | | 6. COLOR OR RACE white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Sept. 23, 1888 | |
| 9. AGE (In years, months, days, hours, minutes) 71 yrs | | 10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. | | 11. IF UNDER 24 HRS. Months 1 Days 1 Hours 1 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Dressel | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. None | | | |
| INFORMANT Louis Plumer | | | | Address Thurmont, Md. RD 1 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 481X DUE TO Acute pulmonary edema Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO Myocardial insufficiency DUE TO Bronchitis and virus in fluenza | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hr. 4 years 4 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from Feb. 26 , 19 60 , to Mar. 1 , 19 60 , that I last saw the deceased alive on Mar. 1 , 19 60 , and that death occurred at 4:45 M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE James K. Gray | | | | ADDRESS (Street, city or town, state) Thurmont-Md. | | | |
| PHYSICIAN'S NAME (Type) James K. Gray | | | | DATE SIGNED 3/2/60 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22b. DATE THEREOF 3-4-60 | | 22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery | |
| 22d. LOCATION (City, town, or county) Thurmont, Maryland | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager | | | | ADDRESS Thurmont, Md. | | 24a. REC'D BY REGISTRAR DATE MAR 7 '60 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Hanna | | | | | | | |

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 be retained by the hospital or attending physician.

4 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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См. также: Введение

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1. The following are the
 2. names of the persons who
 3. have been appointed to
 4. the various committees
 5. of the Board of Directors
 6. of the City of New York
 7. for the year 1901.

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2014-2015 Year

Journal of Management Education 32(1)

1993-3-26

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03276

3320

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
make the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R. # 15, Nr. Frederick | | c. LENGTH OF STAY IN 1b 6 mos. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS Fort Detrick -W. 7th. St. | |
| 3. NAME OF DECEASED (Type or print) Robert L. Ponder | | 4. DATE OF DEATH Month March Day 14 Year 1960 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11/22/35 |
| 9. AGE (In years last birthday) 24 yrs. | | 10. IF UNDER 1 YEAR Months 0 Days 0 | |
| 11. IF UNDER 24 HRS. Hours 0 Min. 0 | | 12. CITIZEN OF WHAT COUNTRY? United States | |
| 13. FATHER'S NAME Louis Ponder | | 14. MOTHER'S MAIDEN NAME Virgie Tucker | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. 7716/59 - 435-50-8803 | |
| 17. INFORMANT Entered | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Skull, Loss of entire brain, Crushed brain, Mul. fractures. DUE TO (b) 816X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | | INTERVAL BETWEEN ONSET AND DEATH Minutes |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car ran under tractor trailer | |
| 20c. TIME OF INJURY Month 3 , Day 14 , Year 1960 1:30 A. M. | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) R. #15 | | 20f. (City or town) (County) (State) Nr. Frederick Frederick, Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE B. O. Thomas | | DATE SIGNED 3/14/60 | |
| EXAMINER'S NAME (Type) B. O. Thomas, M. D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 3/18/1960 | |
| 22c. NAME OF CEMETERY OR CREMATORY GREENWOOD CEMETERY | | 22d. LOCATION (City, town, or county) (State) RUSTON LA. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE L. Martin Roe | | 24a. REC'D BY REGISTRAR DATE MAR 17 '60 | |
| ADDRESS WAYNESBORO, PA. | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3321 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03277

| | | | |
|---|--------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> | | c. LENGTH OF STAY IN 1b <u>3 yrs.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rose Marinos Resturant-Rt. 240A</u> | | / d. STREET ADDRESS <u>Rose Marinos Resturant</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Ja mes Keefer Proctor</u> | | 4. DATE OF DEATH Month <u>March</u> Day <u>2,</u> Year <u>1960</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Ne gro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>Apr. 10- 1901</u> |
| 9. AGE (In years last birthday) <u>58</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>*****</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Frederick Co. Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John Proctor</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u> </u> | |
| 17. INFORMANT <u>Merhle Proctor-5843 Cedar Ave. Phila. Pa.</u> | | Address <u> </u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH <u>?</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u> </u> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | | 20f. (City or town) (County) (State) <u> </u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>B O Thomas</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>B. O. Thoma s, Sr., M. D.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED <u> </u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>3-6-60</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Fairview</u> | | 22d. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>C.E. Hicks 111 Frederick, Maryland</u> | | 24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |
| DATE <u>MAR 7 '60</u> | | | |

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 16
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | |
|-----------------------|--|-------------------|--|---------------------|--|----------------------|--|---------------------|--|------------------------|--|-----------------|--|------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY OF BIRTH | | COUNTRY OF BIRTH | |
| JAMES H. HARRIS | | 45 | | M | | W | | 1880 | | BALTIMORE | | MD | | U.S.A. | |
| RESIDENCE | | OCCUPATION | | EDUCATION | | MARRIAGE | | RELIGION | | POLITICAL | | MILITARY | | SPECIAL | |
| 1234 E. BALTIMORE ST. | | CLOCK REPAIRER | | HIGH SCHOOL | | MARRIED | | METHODIST | | DEMOCRAT | | ARMY | | NONE | |
| DATE OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | | COUNTRY OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | | MEDICAL HISTORY | | SURVIVAL | |
| JAN 15 1910 | | HOME | | BALTIMORE | | MD | | HEART DISEASE | | NATURAL | | HEART DISEASE | | YES | |
| TIME OF DEATH | | TEMPERATURE | | PULSE | | RESPIRATION | | BLOOD PRESSURE | | URINE | | FECES | | SPECIAL | |
| 10:00 AM | | 98.6 | | 72 | | 18 | | 120/80 | | NORMAL | | NORMAL | | NONE | |
| SIGNATURE OF EXAMINER | | TITLE OF EXAMINER | | DATE OF EXAMINATION | | PLACE OF EXAMINATION | | CITY OF EXAMINATION | | COUNTRY OF EXAMINATION | | SPECIAL | | SPECIAL | |
| J. H. HARRIS | | M.D. | | JAN 15 1910 | | HOME | | BALTIMORE | | MD | | NONE | | NONE | |

CERTIFICATE OF DEATH

Reg. Dist. No.

03278

3285

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | | c. LENGTH OF STAY IN 1b 7 wks. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - New London | | | |
| 3. NAME OF DECEASED (Type or print) Charles Wilbert Pryor | | | | d. STREET ADDRESS Mt. Airy Route 1 | | | |
| First Middle Last | | | | 4. DATE OF DEATH Month March Day 15 Year 1960 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Colored | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Nov. 25- 1896 | |
| 9. AGE (In years lost birthday) 63 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | | 11. BIRTHPLACE (State or foreign country) Frederick Co. Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer-Consturition | | | | 10b. KIND OF BUSINESS OR INDUSTRY ***** | | | |
| 13. FATHER'S NAME William Henry Pryor | | | | 14. MOTHER'S MAIDEN NAME Mary Hackey | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | | | 16. SOCIAL SECURITY NO. 220-10-5012 | | | |
| 17. INFORMANT Cordelia Pryor-Mt. Airy Rt. 1 Fred. Md. | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute post. myocardial Infarct 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio sclerosis DUE TO (c) Old healed pulmonary tuberculosis. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old healed pulmonary tuberculosis. | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH 7 weeks 5-10 yrs | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from April 18, 1956 to March 15, 1960 , that I last saw the deceased alive on March 15, 1960 , and that death occurred at 2 P. M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Ralph L. Michels | | | | ADDRESS (Street, city or town, state) Shopping Center Frederick, Md. | | | |
| PHYSICIAN'S NAME (Type) Ralph L. Michels | | | | DATE SIGNED March 17 '60 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Mar. 19-60 | | 22c. NAME OF CEMETERY OR CREMATORY Dorsey Chapel | | 22d. LOCATION (City, town, or county) (State) Frederick Co. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE C.E. Hicks | | | | 24a. REC'D BY REGISTRAR MAR 17 '60 | | | |
| ADDRESS 111 Frederick, Md. | | | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | |

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1933

CERTIFICATE OF DEATH

1933



1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]

10. Name of informant: [illegible]
11. Address of informant: [illegible]
12. Signature of informant: [illegible]
13. Date of completion: [illegible]

14. Name of registrar: [illegible]
15. Signature of registrar: [illegible]
16. Date of registration: [illegible]
17. Name of registrar: [illegible]
18. Signature of registrar: [illegible]
19. Date of registration: [illegible]

02378

CERTIFICATE OF DEATH

02378



1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Date of death: _____

6. Place of death: _____

7. Cause of death: _____

8. Signature of physician: _____

9. Signature of registrar: _____

10. Date of registration: _____

1

INSTRUCTIONS

TO THE ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03280

3322

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|--|---|--|--------------------------------|---|--------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY Frederick | | STATE MARYLAND | | STATE Maryland | | COUNTY Frederick | |
| CITY (If outside corporate limits, write RURAL and give nearest town) Rural Mt. Airy | | LENGTH OF STAY (in this place) 15 yrs. | | CITY (If outside corporate limits, write RURAL and give nearest town) Rural Mt. Airy | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D.# 4 | | | | STREET ADDRESS (If rural give location) R.D.# 4 | | | |
| 3. NAME OF DECEASED (Type or Print) VIRGIE L. RUBY | | | | 4. DATE OF DEATH March 14, 1960 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married | 8. DATE OF BIRTH April 16, 1905 | 9. AGE last birthday 54 yrs. | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Domestic | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William Ruby | | | | 14. MOTHER'S MAIDEN NAME Amanda Horton | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) ----- | | 16. SOCIAL SECURITY NO. ----- | | 17. INFORMANT & ADDRESS Luster P. Fritz, R.D.#4 | | Mt. Airy Maryland | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 174X IMMEDIATE CAUSE (A) Spontaneous | | | | | | Sudden | |
| ANTECEDENT CAUSE(S) DUE TO (B) Cancer - Visceral | | | | | | 2 yrs | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) ----- | | | | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/> | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from 1-8 , 19 59 , to 3/14 , 19 60 , that I last saw the deceased alive on 3/10 , 19 60 , and that death occurred at 7 A. M, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE J. H. Legg | | | | DATE SIGNED 5/14/60 | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | DATE THEREOF 3-17-1960 | | NAME OF CEMETERY OR CREMATORY Prospect Cemetery | | LOCATION (City, town, or county) (State) Frederick Co. Maryland | |
| 24. REC'D BY REGISTRAR DATE MAR 17 '60 | | REGISTRAR'S SIGNATURE Clarence S. Kraus | | 25. FUNERAL DIRECTOR'S SIGNATURE C. M. WALTZ | | ADDRESS Winfield, Maryland | |

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125-126

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— 224 —

1995

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03281

3287

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|--|---|
| 1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> | | | | c. LENGTH OF STAY IN 1b <u>5 hrs.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X RFD # 3, Frederick, Md.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial</u> | | | | 1. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Reinhold</u> Middle <u>RUHLEMANN</u> Last <u>RUHLEMANN</u> | | | | 4. DATE OF DEATH Month <u>March</u> Day <u>18</u> Year <u>1960</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Nov. 14, 1886</u> | |
| 9. AGE (In years last birthday) <u>73</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Meat Cutter</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Markets</u> | | 11. BIRTHPLACE (State or foreign country) <u>Germany</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Unknown</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>578-09-0504</u> | | 17. INFORMANT <u>Lene H. Ruhlemann</u> | | Address <u>Frederick, Md. RD 3</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral pneumonitis</u> <u>492X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio sclerotic heart disease</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Jan. 11, 1960</u> , to <u>March 18, 1960</u> , that I last saw the deceased alive on <u>March 18, 1960</u> , and that death occurred at <u>555 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Shopping Center</u> DATE SIGNED <u> </u> | | | | | | | |
| ACTUAL SIGNATURE <u>Ralph L. Michels, MD</u> M.D. | | | | DATE SIGNED <u> </u> | | | |
| PHYSICIAN'S NAME (Type) <u>Ralph L. Michels M.D.</u> | | | | ADDRESS <u>Frederick, Maryland</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>3-21-60</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Bladensburg, Md. Pr. Geo. C.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Creager</u> | | | | ADDRESS <u>Thurmont, Maryland</u> | | 24a. REC'D BY REGISTRAR DATE <u>MAR 22 '60</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03282

3323

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RURAL</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>EMMA MAY SAYLER</u> | | 4. DATE OF DEATH <u>MARCH 15 1960</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>DEC 13-1873</u> |
| 9. AGE (In years last birthday) <u>86</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>WILLIAM GEISELMAN</u> | | 14. MOTHER'S MAIDEN NAME <u>LAURA STITELY</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>NONE</u> | |
| 17. INFORMANT <u>ISAAC W SAYLER</u> | | Address <u>UNION BRIDGE RURAL</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial degeneration</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes</u> DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>4 wks 6 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>1-4-1959</u> to <u>3-15-1960</u> , that I last saw the deceased alive on <u>3-15-1960</u> , and that death occurred at <u>1:50 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>J. W. Legg</u> M.D. | | ADDRESS (Street, city or town, state) <u>Union Bridge MD</u> | |
| DATE SIGNED <u>3-15-60</u> | | | |
| PHYSICIAN'S NAME (Type) <u>J. W. Legg MD</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>3/18/60</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK</u> | | 22d. LOCATION (City, town, or county) (State) <u>CARROLL CO. MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>D. W. Hughes</u> ADDRESS <u>Union Bridge Md</u> | | 24a. REC'D BY REGISTRAR DATE <u>MAR 21 '60</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hunt</u> | |

055298

CERTIFICATE OF DEATH

| | | | |
|---------------------------------------|--|---|--|
| PLACE OF DEATH HOME | | SEX MALE | |
| DATE OF DEATH JAN 15 1951 | | TIME OF DEATH 10:00 AM | |
| PLACE OF BIRTH BALTIMORE, MARYLAND | | AGE 68 | |
| OCCUPATION RETIRED | | MARITAL STATUS MARRIED | |
| CAUSE OF DEATH HEART DISEASE | | MANNER OF DEATH NATURAL | |
| MEDICAL HISTORY HYPERTENSION | | PRESENT ILLNESS HEART ATTACK | |
| PHYSICIAN'S SIGNATURE J. H. SMITH | | COUNTY CLERK'S SIGNATURE J. H. SMITH | |
| DATE OF SIGNATURE JAN 15 1951 | | PLACE OF SIGNATURE BALTIMORE, MARYLAND | |

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy of the same is to be sent to the local health officer of the county in which the death occurred.

The Registrar of the State Department of Health, Baltimore, Maryland, is to be notified of the death of every person who dies in this State, and the Registrar is to be notified of the death of every person who dies in this State, and the Registrar is to be notified of the death of every person who dies in this State.

The Registrar of the State Department of Health, Baltimore, Maryland, is to be notified of the death of every person who dies in this State, and the Registrar is to be notified of the death of every person who dies in this State, and the Registrar is to be notified of the death of every person who dies in this State.

3324

CERTIFICATE OF DEATH

Reg. Dist. No.

03283

| | | | |
|---|---------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Frederick- Route 3 | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Louise Emma Weihing Schwimer | | 4. DATE OF DEATH Month Day Year March 28th 19 60 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12-23-1902 |
| 9. AGE (In years last birthday) 57 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | 11. IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (State or foreign country) Connecticut | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Martin Weihing | | 14. MOTHER'S MAIDEN NAME Emma Eisehardt | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 041-09-1093 | |
| 17. INFORMANT Joseph Schwimer- Rt. 3- Frederick- Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of the breast 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) with generalized metastases DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 2 yrs. | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Nov. 19, 1959 to March 28, 1960 , that I last saw the deceased alive on March 24, 1960 , and that death occurred at 4:45 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Henry V. Chase | | DATE SIGNED 3/28/60 | |
| PHYSICIAN'S NAME (Type) Dr. H.V. Chase | | Frederick- Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 3-31-1960 | 22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. | 22d. LOCATION (City, town, or county) (State) Fort Myer- Va. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert C. Dailey | | 24a. REC'D BY REGISTRAR DATE MAR 30 '60 | |
| ADDRESS Frederick- Maryland | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1930

CERTIFICATE OF DEATH

1930



1
M
X
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
be retained by the hospital or attending physician.
GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3288
CERTIFICATE OF DEATH

Reg. Dist. No.

03284

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | c. LENGTH OF STAY IN 1b Years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 232 East Fifth Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First JOHNNIE Middle CORNELIA Last SHEWBRIDGE | | 4. DATE OF DEATH Month March Day 26 Year 19 60 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 14 June 1892 |
| 9. AGE (In years lost birthday) yrs. 67 | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Johnnie Nunberger | | 14. MOTHER'S MAIDEN NAME Annie Carey | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Mrs. Mary L. Logan, Baltimore 31, Md. | | 205 S. Register St., | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer, etiology or primary site uncertain 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April , 19 58 , to 3-26- , 19 60 , that I last saw the deceased alive on Jan 30 , 19 60 , and that death occurred at 12:45A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 220 N. Market St. Frederick, Md. DATE SIGNED 28 March 1960 | | | |
| ACTUAL SIGNATURE Rex R. Martin | | M.D. Frederick, Md. | |
| PHYSICIAN'S NAME (Type) Rex R. Martin, M. D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3-29-60 | |
| 22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | | 22d. LOCATION (City, town, or county) (State) Frederick, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | ADDRESS Frederick, Md. | |
| 24a. REC'D BY REGISTRAR DATE MAR 29 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

10524

Carver, Christopher Henry & wife 2 sons

for 30 00
Apr 22 3-24-00

1. **TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03285

3289

| | | | | | | | |
|---|----------------------------------|---|---|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Howard | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Poplar Springs 13X-2 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Mem. Hospital | | | | d. STREET ADDRESS RFD #3, Mt. Airy | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First RALPH Middle - Last SHIPLEY | | | | 4. DATE OF DEATH Month 3 - Day 15 Year 1960 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 9, 1902 | | 9. AGE (In years lost birthday) 57 yrs. | IF UNDER 1 YEAR Months 57 Days 57 Hours 57 Min. | IF UNDER 24 HRS. Months 57 Days 57 Hours 57 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic | | 10b. KIND OF BUSINESS OR INDUSTRY Farm Machinery | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William A. Shipley | | | | 14. MOTHER'S MAIDEN NAME Carrie Dempsey | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. W.W.#2 218-18-0589 | | 17. INFORMANT Address Mrs Arlean F. Shipley, Mt. Airy, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO | | | | | | INTERVAL BETWEEN ONSET AND DEATH 24 hours | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cirrhosis with bleeding esophageal varices | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 2/27 19 60 , to 3/15 19 60 , that (I) (we) lost the deceased on 3/15 19 60 and that death occurred at 7:30 AM, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Richard C. Reynolds | | | | 22b. DATE SIGNED 3/16/60 | | 22c. PHYSICIAN'S NAME (Type) Richard C. Reynolds | |
| 22d. ADDRESS Frederick, Md. | | | | 22e. REC'D BY REGISTRAR DATE MAR 21 '60 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 3/18/60 | | 23c. NAME OF CEMETERY OR CREMATORY Poplar Springs Meth. | | 23d. LOCATION (City, town, or county) (State) Poplar Springs, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Clint L. Mohaworth | | | | 25b. REGISTRAR'S SIGNATURE William L. Kline | | | |

EP

75855

REWARD AND INVESTIGATION OF DEATH

CERTIFICATE OF DEATH

3213



County

State

Age

Sex

Married - Single

Occupation

Date of Birth

Place of Birth

Age

Sex

Married

Occupation

Date

Time

Place

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Burial Director

Signature of Funeral Home

Signature of Undertaker



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3290

CERTIFICATE OF DEATH

Reg. Dist. No.

03286

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jefferson | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First HENRY Middle GOLDSBORO Last STAUFFER | | 4. DATE OF DEATH Month March Day 29 Year 1960 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 15 Feb 1890 |
| 9. AGE (In years last birthday) 70 yrs. | | 10. IF UNDER 1 YEAR Months 70 Days 70 Hours 70 Min. 70 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farm Tenant | | 10b. KIND OF BUSINESS OR INDUSTRY Farming | |
| 11. BIRTHPLACE (State or foreign country) Walkersville, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Clay Stauffer | | 14. MOTHER'S MAIDEN NAME Margaret V. Cramer | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 214-10-4384 | |
| 17. INFORMANT William C. Stauffer (Same as item #2) | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Duodenal ulcer, Benign 541.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) 541.0 DUE TO (c) 541.0 DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 1 yr | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 25 March, 1960 , to 29 March, 1960 , that I last saw the deceased alive on 28 March, 1960 , and that death occurred at 7:05 A.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Melvin E. Lea | | ADDRESS (Street, city or town, state) Frederick Medical Center DATE SIGNED 30 March 1960 | |
| PHYSICIAN'S NAME (Type) Melvin E. Lea, M. D. | | Frederick, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4-1-60 | |
| 22c. NAME OF CEMETERY OR CREMATORY Glade Cemetery | | 22d. LOCATION (City, town, or county) (Stole) Walkersville, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | 24a. REC'D BY REGISTRAR DATE APR 1 '60 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Kiser | | | |

1

Page 4

VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3290

Full Name

John J. Doe

Residence

Age

Sex

Color

Height

Weight

Build

Marital Status

Education

Occupation

Place of Birth

Date of Birth

Cause of Death

Signature of Physician

Witness

Signature of Registrar

Date

Place of Death

1

3291

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03287

| | | | |
|---|-----------------------------------|---|--|
| 1. PLACE OF DEATH o. COUNTY <u>FREDERICK</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>FREDERICK</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u> | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FREDERICK MEMORIAL HOSP</u> | | d. STREET ADDRESS <u>Rte #1</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Patricia</u> Middle <u>Irene</u> Last <u>Stine</u> | | 4. DATE OF DEATH Month <u>march</u> Day <u>1</u> Year <u>1960</u> | |
| 5. SEX <u>female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>February 29, 1960</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 13. FATHER'S NAME <u>Mr. Earl Edward Stines</u> | | 14. MOTHER'S MAIDEN NAME <u>Himes, Catherine Elizabeth</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| | | 17. INFORMANT <u>MOTHER Mrs. EARL E STINE</u> Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hydrocephalus</u> <u>751X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Meningitis</u> DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH <u>Birth defect</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>2/29</u> , 19 <u>60</u> , to <u>3/1</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/29</u> , 19 <u>60</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>James B. Thomas</u> | | ADDRESS (Street, city or town, state) <u>FREDERICK Maryland</u> | |
| PHYSICIAN'S NAME (Type) <u>James B Thomas</u> | | DATE SIGNED <u>3/1/60</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>3/3/1960</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Locust Grove</u> | 22d. LOCATION (City, town, or county) (State) <u>Unionville rural Fred, CO, MD</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>G. B. Barton</u> ADDRESS <u>Walkersville Md</u> | | 24a. REC'D BY REGISTRAR <u>DATE 4-1-60</u> | 24b. REGISTRAR'S SIGNATURE <u>Chase</u> |

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3325

CERTIFICATE OF DEATH

03288

Reg. Dist. No.

| | | | | | | | |
|---|------------------------------|---|--|--|---|--|------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Frederick</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural- Centerville</u> | | | | c. LENGTH OF STAY IN lb <u>life</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ijamsville- P.O.</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>William</u> First <u>Thompson</u> Middle Last | | | | 4. DATE OF DEATH Month <u>3</u> Day <u>26</u> Year <u>1960</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 4-1875</u> | | 9. AGE (In years lost birthday) <u>84</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (State or foreign country) <u>Frederick-CO Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>LLoyd Thompson</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Daffayne Chase</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>220-10-5441</u> | | INFORMANT <u>Ijamsville</u> <u>George Thompson Frederick Co. Md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial heart Disease</u> DUE TO (c) ----- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Advanced hypercholesterolemia</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>20-30 yrs.</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>May 22</u> , 19 <u>56</u> , to <u>March 26</u> , 19 <u>60</u> , that I lost saw the deceased alive on <u>March 21</u> , 19 <u>60</u> , and that death occurred at <u>11 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Shopping Center</u> DATE SIGNED <u>Frederick, Maryland</u> | | | | | | | |
| ACTUAL SIGNATURE <u>Ralph L. Michels</u> M.D. | | | | DATE SIGNED <u>Frederick, Maryland</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Ralph L. Michels</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>3-29-60</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Ebernezer</u> | | 22d. LOCATION (City, town, or county) (State) <u>Frederick. C.O. Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>L. E. Hicks</u> ADDRESS <u>Frederick, Md</u> | | | | 24a. REC'D BY REGISTRAR <u>MAR 30 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u> | |

08288

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03289

3326

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Burkittsville | | c. LENGTH OF STAY IN 1b years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Burkittsville | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS 1 | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Walter Middle F. Last Thrasher | | | | 4. DATE OF DEATH Month 3 Day 6 Year 1960 | | | |
| 5. SEX male | | 6. COLOR OR RACE white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 2/8/1899 | |
| 9. AGE (In years last birthday) 61 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | | 11. IF UNDER 24 HRS. | | 12. BIRTHPLACE (State or foreign country) Maryland | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farm owner | | | | 10b. KIND OF BUSINESS OR INDUSTRY farm | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME William Thrasher | | | | 14. MOTHER'S MAIDEN NAME Ella Miller | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | | | 16. SOCIAL SECURITY NO. INFORMANT Mrs. Helen Thrasher, Burkittsville, Md | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis lying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3-4 min unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21. I certify that I attended the deceased from 8/1, 1957, to 3/2, 1960, that I last saw the deceased alive on 3/2, 1960, and that death occurred at 1:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Middletown, Md 3/5/60 ACTUAL SIGNATURE Dr. Kenneth Henson M.D. Dr. Kenneth Henson PHYSICIAN'S NAME (Type) Middletown, Md. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 22b. DATE THEREOF 3/9/1960 | | 22c. NAME OF CEMETERY OR CREMATORY Pleasant View Cemetery | | 22d. LOCATION (City, town, or county) (State) Frederick Co., Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Co., Middletown, Md. | | | | 24a. REC'D BY REGISTRAR DATE MAR 10 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Hume | |

0828

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

CERTIFICATE OF DEATH

3326

[Faint, mostly illegible text from the reverse side of the document, including fields for name, date, and cause of death.]

3327
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|-------------------------------------|--|--|
| 1. PLACE OF DEATH o. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Loudoun | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Ijamsville | | c. LENGTH OF STAY IN 1b 3 yrs | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Inggs Hospital | | d. STREET ADDRESS Leesburg | |
| 3. NAME OF DECEASED (Type or print) Horatio First H Middle Trundle Last | | 4. DATE OF DEATH March 12 19 60 Month Day Year | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov 28 1866 |
| 9. AGE (In years last birthday) 93 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Leesburg, Va. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Horatio Trundle | | 14. MOTHER'S MAIDEN NAME Elizabeth Travers | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. INFORMANT Address Mrs. H. H. Trundle Leesburg, Va. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 yrs 20 yrs | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 6 , 19 57 , to March 12 , 19 60 , that I last saw the deceased alive on March 12 , 19 60 , and that death occurred at 7.30 A.M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Joseph Lerner M.D. | | ADDRESS (Street, city or town, state) Ijamsville Md. DATE SIGNED March 12 1960 | |
| PHYSICIAN'S NAME (Type) Joseph Lerner M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 14 Mar. 60 | 22c. NAME OF CEMETERY OR CREMATORY Union | 22d. LOCATION (City, town, or county) (State) Leesburg, Va. |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. A. Harrison ADDRESS W. A. Harrison | | 24a. REC'D BY REGISTRAR MAR 16 '60 | 24b. REGISTRAR'S SIGNATURE Arthur L. Thoma |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10. The following table shows the number of people who attended the 2008 Summer Olympics in Beijing, China. The data is presented in a table with 2 rows and 10 columns. The first row lists the countries, and the second row lists the number of people who attended. The data is as follows:

262

1956

CERTIFICATE OF DEATH

Reg. Dist. No.

03291

3328

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|--|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#5 | | c. LENGTH OF STAY IN 1b Since-1949 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridge Road-Braddock Heights | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First ELINOR Middle WARE Last WARE | | 4. DATE OF DEATH Month March Day 24 Year 1960 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4 March 1911 |
| 9. AGE (In years last birthday) 49 yrs. | | 10. IF UNDER 1 YEAR Months 49 Days 24 Hours 19 Min. | 11. IF UNDER 24 HRS. Months 49 Days 24 Hours 19 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Professor | | 10b. KIND OF BUSINESS OR INDUSTRY Hood College | |
| 11. BIRTHPLACE (State or foreign country) Geneva, New York | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Walter C. Ware | | 14. MOTHER'S MAIDEN NAME Zaida Quick | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 220-30-9305 | |
| 17. INFORMANT Miss Elizabeth L. Towle (Same as item #1) | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of breast 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 1/2 yrs | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from March 1, 1960 to March 24, 1960 , that I last saw the deceased alive on March 23, 1960 , and that death occurred at 4 A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 228 N. Market St., Frederick, Md. DATE SIGNED 25 March 1960 | | | |
| ACTUAL SIGNATURE L. R. Schoolman | | M.D. 228 N. Market St., Frederick, Md. | |
| PHYSICIAN'S NAME (Type) L. R. Schoolman, M. D. | | Frederick, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF 3-25-60 | |
| 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) Taunton, Massachusetts | |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | 24a. REC'D BY REGISTRAR DATE MAR 28 '60 | |
| 24b. REGISTRAR'S SIGNATURE Charles E. Hume | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3328

CERTIFICATE OF DEATH

3328

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3329 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03292

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural | | c. LENGTH OF STAY IN 1b Minutes | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3 Miles North Of Frederick on U.S.#15 | | e. STREET ADDRESS 108 West 9th Street | |
| 3. NAME OF DECEASED (Type or print) First ROBERT Middle LEE ROY Last WHEELAND | | 4. DATE OF DEATH Month March Day 14 Year 1960 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH January 2, 1932 |
| 9. AGE (In years last birthday) 28 yrs. | | 10. IF UNDER 1 YEAR Months 0 Days 0 | 11. IF UNDER 24 HRS. Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY Automobiles | |
| 11. BIRTHPLACE (State or foreign country) Ohio | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Lucille Wheeland | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes Korean Conflict | | 16. SOCIAL SECURITY NO. 280-26-3975 | |
| 17. INFORMANT Mrs. Wilna Jean Wheeland, Dickerson, Maryland | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CRUSHED SKULL WITH DISTRUCTION OF BRAIN 816X DUE TO Crushed Chest Conditions, if any, which gave rise to immediate cause (b) Multiple Fractures (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Auto Ran Beneath Tractor Trailer | | INTERVAL BETWEEN ONSET AND DEATH Instant 11 11 | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto Ran Beneath Tractor Trailer | |
| 20c. TIME OF INJURY Month, Day, Year 2:15 p.m. 3/14/ 19 60 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway | | 20f. (City or town) (County) (State) Harmony Grove, Frederick, Md. | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined monner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE B. O. Thomas M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) B. O. Thomas, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF 3/14/1960 | |
| 22c. NAME OF CEMETERY OR CREMATORY M. R. Etchison & Son, Frederick, Maryland | | 22d. LOCATION (City, town, or county) (State) Hanover Indiana | |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | 24a. REC'D BY REGISTRAR DATE MAR 15 '60 | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| <p>NAME OF DECEASED JAMES H. HARRIS</p> | | <p>AGE 45</p> | | <p>SEX Male</p> | | <p>RACE White</p> | |
| <p>RESIDENCE 1234 Main St., Baltimore, Md.</p> | | <p>DATE OF DEATH March 15, 1911</p> | | <p>TIME OF DEATH 10:30 A.M.</p> | | <p>PLACE OF DEATH Home</p> | |
| <p>CAUSE OF DEATH Myocardial Infarction</p> | | <p>MANNER OF DEATH Natural</p> | | <p>EDUCATION High School</p> | | <p>OCCUPATION Clerk</p> | |
| <p>PREVIOUS ILLNESS None</p> | | <p>PREVIOUS SURGERY None</p> | | <p>PREVIOUS TRAUMA None</p> | | <p>PREVIOUS DRUGS None</p> | |
| <p>PHYSICIAN'S NAME Dr. J. H. Smith</p> | | <p>PHYSICIAN'S ADDRESS 567 N. Broadway, Baltimore, Md.</p> | | <p>PHYSICIAN'S SIGNATURE J. H. Smith</p> | | <p>PHYSICIAN'S TITLE M.D.</p> | |
| <p>EXAMINER'S NAME Dr. A. B. Jones</p> | | <p>EXAMINER'S ADDRESS 890 E. Pratt St., Baltimore, Md.</p> | | <p>EXAMINER'S SIGNATURE A. B. Jones</p> | | <p>EXAMINER'S TITLE M.D.</p> | |
| <p>DATE OF EXAMINATION March 15, 1911</p> | | <p>TIME OF EXAMINATION 11:00 A.M.</p> | | <p>PLACE OF EXAMINATION Home</p> | | <p>REMARKS The body was found in bed, deceased was found dead.</p> | |

3292

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|---|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | | c. LENGTH OF STAY IN 1b 5 Weeks | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital | | | | d. STREET ADDRESS 1 | | | |
| 3. NAME OF DECEASED (Type or print) First HARRY Middle FRANCIS Last WICKHAM | | | | 4. DATE OF DEATH Month March Day 10 Year 1960 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 23, 1892 | | 9. AGE (In years last birthday) 67 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming | | 10b. KIND OF BUSINESS OR INDUSTRY Farm Owner | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Robert Francis Wickham | | | | 14. MOTHER'S MAIDEN NAME Annie McKenzie | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 220-34-1059 | | INFORMANT Address Mrs. Mabel M. Wickham-Same as Item #2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart disease with 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Congestive heart failure DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 4 year | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 4 year |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan , 1958, to March 10 , 1960, that I lost the deceased alive on March 9 , 1960, and that death occurred at 3:35 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) East Church Street DATE SIGNED 3/11/60 ACTUAL SIGNATURE Henry V. Chase M.D. PHYSICIAN'S NAME (Type) Henry V. Chase, M.D. Frederick, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Mar. 12, 1960 | | 22c. NAME OF CEMETERY OR CREMATORY St. Mark's Cemetery | | 22d. LOCATION (City, town, or county) (State) Frederick County, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | | | 24a. REC'D BY REGISTRAR DATE MAR 14 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Kline | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

1938

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3293

CERTIFICATE OF DEATH

03294

Reg. Dist. No.

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | c. LENGTH OF STAY IN 1b Since 3-18-60 | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-- Mt. Airy 06X-2 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital | | d. STREET ADDRESS | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Daniel Middle Williams Last Williams | | 4. DATE OF DEATH Month March Day 21 Year 1960 | |
| 5. SEX male | 6. COLOR OR RACE colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5-3-1904 |
| 9. AGE (In years last birthday) 55 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer | 11. BIRTHPLACE (State or foreign country) Maryland |
| 10b. KIND OF BUSINESS OR INDUSTRY construction | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Daniel Williams | | 14. MOTHER'S MAIDEN NAME Lucy Ryan | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. ? | |
| 17. INFORMANT Mabel Williams, Mt. Airy, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Pyelonephritis DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH 1 yr. 10 yrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 3/18 , 19 60 , to 3/21 , 19 60 , that I last saw the deceased alive on 3/21 , 19 60 , and that death occurred at 4:55 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Henry V. Chase M.D. | | ADDRESS (Street, city or town, state) DATE SIGNED 4 E. Church St 3/21/60 | |
| PHYSICIAN'S NAME (Type) Henry V. Chase, M.D. | | Frederick Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 3-24-1960 | 22c. NAME OF CEMETERY OR CREMATORY Mt. Zion | 22d. LOCATION (City, town, or county) (State) Carroll Co., Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE C.M. Waltz | | ADDRESS Winfield, Maryland | 24a. REC'D BY REGISTRAR DATE MAR 24 '60 |
| | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | |

1948-49 - 1949-50

$$C_{\text{max}} = 3.2 \text{ mg/mL} \quad \text{and} \quad C_{\text{min}} = 0.05 \text{ mg/mL}$$

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Label Williams, W. R. 11/2/50

3294

CERTIFICATE OF DEATH

Reg. Dist. No.

03295

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|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Carroll | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | c. LENGTH OF STAY IN 1b Since 4-16-58 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Maryland Odd Fellows Home | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick, Maryland 06X-2 | |
| 3. NAME OF DECEASED (Type or print) First IVA Middle VIOLA Last WOOTTON | | 4. DATE OF DEATH Month March Day 7 Year 19 60 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6 June 1880 |
| 9. AGE (In years last birthday) 79 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | 11. IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John O. Perin | | 14. MOTHER'S MAIDEN NAME Emma F. Burkins | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Odd Fellows Home Records (Same as item #1) | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 2 Weeks | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan. , 19 60 , to March 7 , 19 60 , that I last saw the deceased alive on March 7 , 19 60 , and that death occurred at 11:10 P.M. , from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) 4 E. Church St. DATE SIGNED 8 March 1960 | |
| ACTUAL SIGNATURE William M. Smith M.D. | | PHYSICIAN'S NAME (Type) William M. Smith, M. D. Frederick, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3/10/60 | |
| 22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard | | 24a. REC'D BY REGISTRAR DATE MAR 10 '60 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Kinn | | | |

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

03205

CERTIFICATE OF DEATH

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PROVIDENCE, RHODE ISLAND

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

AGE

SEX